

# Exhibit B

**CENTER FOR DRUG EVALUATION AND  
RESEARCH**

***APPLICATION NUMBER:***

**020687Orig1s020**

**MEDICAL REVIEW(S)**

## Clinical Review:

(b) (6) and (b) (6)  
 NDA 020687/S-020- Mifeprex

## CLINICAL REVIEW

Application Type	SE-2 Efficacy Supplement
Application Number(s)	NDA 020687/S-020
Priority or Standard	Standard
Submit Date(s)	May 28, 2015
Received Date(s)	May 29, 2015
PDUFA Goal Date	March 29, 2016
Division / Office	(b) (6)
Reviewer Name(s)	(b) (6) and (b) (6)
Review Completion Date	March 29, 2016
Established Name	Mifepristone
(Proposed) Trade Name	Mifeprex
Therapeutic Class	Progestin antagonist
Applicant	Danco Laboratories, LLC
Formulation(s)	Oral Tablet
Dosing Regimen	For pregnancies through 70 days gestation: Mifeprex 200 mg tablet orally followed in 24-48 hours by 800 mcg buccal misoprostol.
Indication(s)	Mifeprex is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation.
Intended Population(s)	Pregnant women who desire a medical termination through 70 days gestation.

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## 1 Recommendations/Risk Benefit Assessment

This NDA supplement from the Applicant, Danco Laboratories, LLC (called Danco or the Applicant throughout this clinical review), requested the following changes to the NDA for Mifeprex, approved 15 years ago in September 2000.

Changes proposed by the Applicant:

1. Change the dosing regimen: Decrease mifepristone dose from 600 to 200 mg, followed by misoprostol at a dose increased from 400 mcg to 800 mcg, administered buccally instead of orally
2. Remove the statement in labeling that administration of misoprostol must be done in-clinic, to allow for administration at home or other location convenient for the woman.
3. Administration of misoprostol at 24-48 hours instead of 48 hours after Mifeprex
4. Follow-up needed, but not restricted to in-clinic at 14 days after Mifeprex
5. Increase the gestational age from 49 days to 70 days
6. Change the labeled time for expulsion of the products of conception from 4-24 hours to 2-24 hours post misoprostol administration
7. Add that a repeat 800 mcg buccal dose of misoprostol may be used if needed
8. Change “physician” to “(b) (4) in the label and Risk Evaluation and Mitigation Strategies (REMS) document
9. Change indication to add reference to use of misoprostol: “Mifeprex is indicated, in a regimen with misoprostol, for the medical termination of pregnancy through 70 days gestation.”
10. Remove references to “under Federal law” from the Prescriber’s Agreement
11. Address the Pediatric Research Equity Act (PREA) requirement for pediatric studies

Each of these 11 items will be discussed in the appropriate section of this review, generally under Section 6: Review of Efficacy and Section 7: Review of Safety. Four of the items, namely Number 8-11, are primarily regulatory and/or legal. They are discussed in Sections 1.3 and 9.4 (REMS recommendations and Prescriber’s Agreement), 7.6.4 (PREA), and 9.2 (Labeling recommendation). Additional information is found in Section 7.7 (2) on the change to “(b) (4) Section 7.7 (3) on “under Federal law”, and Section 7.7 (4) on the reference to use of misoprostol.

### 1.1 Recommendation on Regulatory Action

The clinical reviewers recommend an approval action for this efficacy supplement.

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**1.2 Risk Benefit Assessment**

1. Decrease mifepristone dose from 600 to 200 mg, followed by misoprostol at a dose increased from 400 mcg to 800 mcg, administered buccally instead of orally.

The Applicant has submitted sufficient evidence from the published medical literature to demonstrate that decreasing the dose of Mifeprex from 600 mg to 200 mg while increasing the dose of misoprostol from 400 to 800 mcg is safe and efficacious for termination of pregnancy through 70 days gestation. The risk/benefit balance favors approval.

There is sufficient evidence that a dosing regimen with buccal administration of 800 mcg misoprostol is safe and effective. This change in the dosing regimen should be approved.

2. Allow administration of misoprostol outside of the clinic:

Based on the evidence submitted by the Applicant, a dosing regimen that includes administration of misoprostol outside of the clinic is safe and effective for termination of pregnancy through 70 days gestation; labeling should be revised to remove the requirement for in-clinic dosing of misoprostol

3. Administration of misoprostol at 24-48 hours instead of 48 hours after Mifeprex:

The available evidence supports that a dosing regimen that provides for administration of misoprostol 24-48 hours after administration of Mifeprex is safe and effective. The risk/benefit assessment demonstrates that this change in the dosing regimen should be approved.

4. Follow-up needed, but not restricted to in-clinic at 14 days after Mifeprex:

Based on the evidence submitted by the Applicant supporting this change, flexibility in timing and method of follow-up after medical abortion is safe. Labeling should be revised to remove the requirement for in-clinic follow-up at 14 days.

5. Increase the gestational age from 49 days to 70 days:

As detailed in the following review, the Applicant has submitted sufficient evidence for the safety and efficacy of medical abortion with Mifeprex, in a regimen with misoprostol, through 70 days gestation. The risk/benefit assessment supports the approval of the new dosing regimen up through 70 days gestation.

6. Change the labeled time for expulsion of the products of conception from 4-24 hours to 2-24 hours post misoprostol administration:

The Applicant has submitted sufficient data from the published medical literature to support approval of a change in the label to note time to expulsion ranges from 2-24 hours.

7. Add that a repeat 800 mcg buccal dose of misoprostol may be used if needed:

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The Applicant has submitted sufficient evidence to support that a repeat dose of misoprostol may be used through 70 days gestation to complete expulsion of the products of conception if needed. The risk/benefit assessment supports approval of this change. There have been rare reports of uterine rupture with use of misoprostol in women with prior uterine scar(s). This information should be added to the Mifeprex label.

8. Change “physician” to “(b) (4) in the labeling and Risk Evaluation and Mitigation Strategies (REMS) document:

The Applicant has submitted sufficient data to support that Mifeprex is safe and effective when prescribed by midlevel practitioners as well as by physicians. Therefore, the term “licensed physician” was changed in the label and REMS materials to “healthcare provider who prescribes.” This broader category of providers will still have to meet the certification criteria specified in the Prescriber Agreement Form.

9. Change the approved indication to add reference to use of misoprostol: “Mifeprex is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation.” Based on current Agency labeling practice regarding drugs used together in a treatment regimen, the addition of misoprostol to the Indication Statement for Mifeprex should be approved.

10. Remove references to “under Federal law” from the Prescriber Agreement:

The Agency has determined that there is no precedent for using this phrase in other REMS, nor is there any clinical rationale for including it; therefore, it is acceptable to remove “under Federal law” from the Prescriber Agreement Form.

11. Address the Pediatric Research Equity Act (PREA) requirement for pediatric studies:

The Applicant has submitted sufficient evidence from the published medical literature to address the PREA requirement for this supplemental application. The Applicant has demonstrated that Mifeprex is safe and effective in postmenarchal females, including those under 17 years of age. (b) (6) concurred with granting a partial waiver under PREA in patients ages birth to 12 years of age who are premenarche.

### 1.3 Recommendations for Postmarket Risk Evaluation and Mitigation Strategies

Changes proposed in this efficacy supplement entailed a number of modifications to the current Risk Evaluation and Mitigation Strategy (REMS) for Mifeprex. See Section 9.4 for full details. The (b) (6) (b) (6) concurs with the (b) (6) (b) (6) evaluation of the REMS modifications, which include:

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- Removal of “under Federal law” from the Prescriber Agreement Form is acceptable (see discussion in Additional Submissions / Issues).
- The term “healthcare providers who prescribe” is preferable to the Applicant’s proposed “ (b) (4) (see discussion in Additional Submissions / Issues).
- It is appropriate to modify the current adverse event reporting requirements under the REMS, which are currently outlined in the Prescriber’s Agreement to include “hospitalization, transfusion or other serious event.” Under these requirements, healthcare providers report certain adverse events to the Applicant, which then is required to report the adverse events to FDA. FDA has received such reports for 15 years, and it has determined that the safety profile of Mifepr is well-characterized, that no new safety concerns have arisen in recent years, and that the known serious risks occur rarely. For this reason, ongoing reporting by certified healthcare providers to the Applicant of all of the specified adverse events is no longer warranted. . It should be noted that the Applicant will still be required by law, as is every NDA holder, to report serious, unexpected adverse events as 15-day safety reports, and to submit non-expedited individual case safety reports, and periodic adverse drug experience reports.

(b) (6) concurs with the following modifications recommended by (b) (6)

- Removal of the Medication Guide (MG) from the REMS. The MG will remain a required part of labeling and will be required to be provided to patients consistent with the requirements in 21 CFR part 208. FDA has been maintaining MGs as labeling but removing them from REMS when, as here, inclusion in REMS is not necessary to ensure that the benefits of a drug outweigh the risks, such as when the MG is redundant and not providing additional use or information to the patient about the risk(s) the REMS is intended to mitigate. This is consistent with ongoing efforts to streamline REMS by allowing for updates to the MG without need for a REMS modification.
- Removal of the Patient Agreement form (ETASU D). This decision was based on the well-established safety profile of Mifepr, as well as the fact that the small numbers of practitioners who provide abortion care in the US use informed consent practices that are duplicated of the current Patient Agreement and thus the Patient Agreement is no longer necessary to ensure that the benefits of the drug outweigh the risks.
- Revision of the Prescriber Agreement Form to reflect changes to labeling revisions pursuant to the proposed efficacy supplement, and to improve the flow of the document.
- Revision of the REMS goals to reflect the above changes

#### 1.4 Recommendations for Postmarket Requirements and Commitments

There are no recommendations for postmarket requirements or commitments for this efficacy supplement.

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## 2 Introduction and Regulatory Background

### 2.1 Product Regulatory Information

On September 28, 2000, FDA approved Mifeprex for the medical termination of intrauterine pregnancy through 49 days' (7 weeks) pregnancy (NDA 20-687). The application was approved under 21 CFR part 314, subpart H, "Accelerated Approval of New Drugs for Serious or Life-Threatening Illnesses" (subpart H). This subpart applies to certain new drug products that have been studied for their safety and effectiveness in treating serious or life-threatening illnesses and that provide meaningful therapeutic benefit to patients over existing treatments." Specifically, § 314.520 of subpart H provides for approval with restrictions that are needed to assure the safe use of the drug product. In accordance with § 314.520, FDA restricted the distribution of Mifeprex as specified in the approval letter, including a requirement that Mifeprex be provided by or under the supervision of a physician who meets certain qualifications specified in the letter.

The September 28, 2000, approval letter also listed two Phase 4 commitments that the then-applicant of the Mifeprex NDA (i.e., the Population Council) agreed to meet:

1. A cohort-based study of safety outcomes of patients having medical abortion under the care of physicians with surgical intervention skills compared to physicians who refer their patients for surgical intervention. Previous study questions related to age, smoking, and follow-up on Day 14 (compliance with return visit) were incorporated into this cohort study, as well as an audit of signed Patient Agreement forms.
2. A surveillance study on outcomes of ongoing pregnancies.

In addition, the 2000 approval letter stated that FDA was waiving the pediatric study requirement in 21 CFR 314.55.

Effective October 31, 2002, the Population Council transferred ownership of the Mifeprex NDA to Danco Laboratories, LLC (Danco).

### 2.2 Tables of Currently Available Treatments for Proposed Indications

In the US there are no other approved products for the medical termination of first trimester pregnancy. Misoprostol alone or in combination with methotrexate has been used for early medical abortion (MAB), with much lower success than Mifeprex.<sup>1</sup>

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<sup>1</sup> American College of Obstetricians and Gynecologists. Practice bulletin No. 143: medical management of first-trimester abortion. *Obstet Gynecol* 2014;123(3):676-92. doi:10.1097/01.AOG.0000444454.67279.7d.

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**2.3 Availability of Proposed Active Ingredient in the United States**

Mifepristone: The only other FDA approval for mifepristone is the product Korlym, approved under NDA 202107 on February 17, 2012 for the control of hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing's syndrome who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery.

**2.4 Important Safety Issues with Consideration to Related Drugs**

Korlym (mifepristone) is indicated to control hyperglycemia secondary to hypercortisolism in adult patients with endogenous Cushing's syndrome who have type 2 diabetes mellitus or glucose intolerance and have failed surgery or are not candidates for surgery. Korlym is taken in oral doses of 300 mg to 1200 mg daily. It is contraindicated in pregnancy, patients taking simvastatin, lovastatin and CYP3A substrates with narrow therapeutic ranges, patients on corticosteroids for lifesaving purposes, and women with unexplained vaginal bleeding or endometrial hyperplasia with atypia or endometrial carcinoma. The label<sup>2</sup> provides warnings and precautions regarding adrenal insufficiency, hypokalemia, vaginal bleeding and endometrial changes, QT prolongation, exacerbation or deterioration of conditions treated with corticosteroids, use of strong CYP3A inhibitors, and opportunistic infections with *Pneumocystis jiroveci* pneumonia in patients with Cushing's. Adverse reactions noted in >20% of patients in clinical trials with Korlym included nausea, fatigue, headache, hypokalemia, arthralgia, vomiting, peripheral edema, hypertension, dizziness, decreased appetite and endometrial hypertrophy.

**Reviewer comment:**

**Some of the adverse events noted with Korlym are also seen with Mifeprrex, such as nausea and vomiting. However, Korlym is taken in higher doses, in a chronic, daily fashion unlike the single 200 mg dose of Mifeprrex that is the subject of this supplement; the rate of adverse events with Mifeprrex is much lower.**

Ella (ulipristal acetate) is a progesterone agonist/antagonist emergency contraceptive indicated for prevention of pregnancy following unprotected intercourse or a known or suspected contraceptive failure. The **ella** label<sup>3</sup> notes that in clinical trials, the most common adverse reactions ( $\geq 10\%$ ) in women receiving **ella** were headache (18% overall) and nausea (12% overall) and abdominal and upper abdominal pain (12% overall).

Due to **ella's** high affinity binding to the progesterone receptor, use of **ella** may reduce the contraceptive action of regular hormonal contraceptive methods. The label notes that after **ella** intake, menses sometimes occur earlier or later than expected by a few

<sup>2</sup> [http://www.accessdata.fda.gov/drugsatfda\\_docs/label/2012/202107s000lbl.pdf](http://www.accessdata.fda.gov/drugsatfda_docs/label/2012/202107s000lbl.pdf)

<sup>3</sup> [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2010/022474s000lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022474s000lbl.pdf)

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days. In clinical trials, cycle length was increased by a mean of 2.5 days but returned to normal in the subsequent cycle. Seven percent of subjects reported menses occurring more than 7 days earlier than expected, and 19% reported a delay of more than 7 days. The label recommends that women rule out pregnancy if the expected menses is delayed by more than one week. Nine percent of women studied reported intermenstrual bleeding after use of **ella**.

**Reviewer comment:**

**Ella is for occasional use and is not to be used as a regular contraceptive method. As such, the drug is not recommended for repeated use in the same menstrual cycle. The safety and efficacy of repeat use within the same cycle has not been evaluated. A single dose of ella does not appear to result in serious adverse events.**

## 2.5 Summary of Presubmission Regulatory Activity Related to Submission

A pre-NDA meeting was held with the Applicant on January 29, 2015. The following items, among others, were discussed:

- New dosing regimen
- Proposal to have (b) (4)
- Use up to (b) (4) days' gestation
- Change in the interval between Mifeprrex and misoprostol administration to 24-48 hours
- Revision of the labeled time to expulsion after misoprostol is administered
- Use of the term “ (b) (4) in the approval and label to describe who may obtain and dispense Mifeprrex
- Deletion of “under Federal law” in the Prescriber’s Agreement
- PREA requirements
- Regulatory pathway for approval

## 2.6 Other Relevant Background Information

Since the approval in France and China in 1988, mifepristone for MAB is currently approved in 62 countries globally<sup>4</sup>; see the list and dates of approval in Appendix 9.7.

Prior to the Mifeprrex approval by the FDA, mifepristone had also been approved in the UK in 1991. In the UK, the current therapeutic indications include:

- Medical alternative to surgical termination of intrauterine pregnancy up to 63 days gestation based on the first day of the last menstrual period
- Softening and dilatation of the cervix uteri prior to mechanical cervical dilatation for pregnancy termination during the first trimester

<sup>4</sup> Gynuity website, [www.gynuity.org](http://www.gynuity.org), Medical Abortion in Developing Countries- List of Mifepristone Approvals.

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- For use with prostaglandin analogues for termination of pregnancy for medical reasons beyond the first trimester
- Labour induction in foetal death in utero<sup>5</sup>

The estimated cumulative use of Mifeprex in the US since the 2000 approval is 2.5 million uses. Estimated global occurrence of MAB and SAB combined was 43.8 million abortions in 2008 (Guttmacher Institute data)<sup>6</sup>. MAB has been increasingly used as its efficacy and safety have become well-established by both research and experience, and serious complications have proven to be extremely rare.<sup>7</sup> Medical abortion comprises 16.5% of all abortions in the US, 25.2% of all abortions at or before 9 weeks of gestation<sup>1</sup>, and based on data from 40 reporting areas sending data to the CDC, 30.8% of all abortions at or before 8 weeks gestation (2012 data).<sup>8</sup> In 2011, approximately 239,400 medical abortions were performed, which was a 20% increase from 2008 data.<sup>9</sup> Data show that in the most recently reported 12 months (September 29, 2014-September 28, 2015), (b) (4) Mifeprex tablets were distributed in the US (NDA 20687 SD # 650, Annual Report-15, submitted October 09, 2015). Further, the vast majority of practitioners in the US who provide medical abortion services use a regimen other than the FDA-approved one. In 2008, Wiegerinck et al published a survey of members of the National Abortion Federation which showed that only 4% of facilities were using the current FDA-approved regimen.<sup>10</sup>

It is noteworthy that ten years ago, the combination of mifepristone and misoprostol for medical abortion was included on the World Health Organization (WHO) Model list of Essential Medicines for termination of pregnancy where legal and acceptable, up to 9 weeks of gestation.<sup>11</sup> Several other national and international organizations have also endorsed the safe use of medical abortion up to 9 and 10 weeks of gestation. This topic will be discussed thoroughly in the Efficacy and Safety Sections.

<sup>5</sup> Mifegyne Summary of Product Characteristics. Exelgyn Laboratories- June 2013. <https://www.medicines.org.uk/emc/medicine/617>

<sup>6</sup> Sedgh G et al., Induced abortion: incidence and trends worldwide from 1995 to 2008. Lancet, 2012;379:625-32.

<sup>7</sup> Cleland K, Smith N. Aligning mifepristone regulation with evidence: driving policy change using 15 years of excellent safety data. Contraception 2015;92:179-81.

<sup>8</sup> Pazol K, Creanga AA, Zane SB, Burley KD, Jamieson DJ. Abortion surveillance--United States, Centers for Disease Control and Prevention (CDC). MMWR Surveill Summ 2012;61(SS-8):1-44 and Surveillance Summaries Nov 27, 2015; 64(SS10):1-40.

<sup>9</sup> Jones RK, Jerman J. Abortion incidence and service availability in the United States, 2011. Perspectives on Sexual and Reproductive Health 2014;46(1):3-14.doi10.1363/46e0414.

<sup>10</sup> Wiegerinck MMJ, Jones HE, O'Connell, K, Lichtenberg ES, Paul M, Westhoff CL. Medical abortion practices: a survey of National Abortion Federation members in the United States. Contraception 2008;78:486-491.

<sup>11</sup> World Health Organization April 2015 Model Lists of Essential Medicines Available online at <http://www.who.int/medicines/publications/essentialmedicines/en/>.

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MAB is a choice that women have available in many areas, especially urban, in the US, although it should be noted that some geographical areas in the US have very limited availability of both the surgical and medical options or even one option for early pregnancy termination.

The primary advantages of having a MAB compared to a surgical abortion (SAB) are the following:

- Limited or no anesthesia
- Limited likelihood of any surgical intervention

**Reviewer's Comment:**

A very small number of physicians currently provide early medical terminations. In the most recent REMS update from the Applicant (stamp date June 3, 2015), the cumulative number of certified prescribers since 2000 is only (b) (4). Between May 1, 2012 and April 30, 2015, the number of new prescribers was (b) (4) and the number of prescribers ordering Mifeprex was (b) (4) during this 3-year period. The number of healthcare providers that are performing early SAB is not documented.

### **3 Ethics and Good Clinical Practices**

#### **3.1 Submission Quality and Integrity**

Because this submission did not rely on datasets from any of the clinical trials, no FDA inspections were performed at clinical sites. The authors of the numerous articles, however, have published widely in peer-reviewed medical journals.

#### **3.2 Compliance with Good Clinical Practices**

This submission relies on findings from the published medical literature. The majority of the publications included a statement that the study was conducted under institutional review board (IRB) or Ethical Review Committee approval and the women gave informed consent.

#### **3.3 Financial Disclosures**

None were submitted or required.

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## 4 Significant Efficacy/Safety Issues Related to Other Review Disciplines

### 4.1 Chemistry Manufacturing and Controls (CMC)

On March 10, 2016, a separate supplement approved the packaging of a single 200 mg tablet of mifepristone compared to the current 3 tablets in a blister pack. Each packet will have an individual barcode.

**Reviewer comment:**

**The approval of single tablet packaging should make recording the barcode of the mifepristone tablet in the patient record (as provided in the REMS) easier as the new proposed dosing regimen uses only one 200 mg mifepristone tablet compared to the previously approved regimen of three tablets.**

(b) (6), reviewed the PLR conversion of the label. Her review, dated January 11, 2016 states the following:

"No changes have been made in the approved chemistry, manufacturing and controls. The approved 200 mg tablet will be used. This review evaluates the PLR conversion of the labeling. Sections 3, 11, and 16 of the PLR labeling, and the Highlights of Prescribing Information, have been evaluated from a chemistry perspective.

**Overall Evaluation:** Acceptable. The labeling provided in Section 3, Section 11, and Section 16, and the Highlights of Prescribing Information, is identical in content to the approved information. The PLR conversion labeling, therefore, is acceptable from a chemistry perspective. The PLR label also corresponds to the content and format required in 21 CFR 201.57.

**Reviewer comment:**

**We agree with the conclusions in the CMC review of the PLR conversion of the label.**

### 4.2 Clinical Microbiology

The chemistry (CMC) reviewers determined that a microbiology review was not needed for this efficacy supplement.

### 4.3 Preclinical Pharmacology/Toxicology

Please refer to the Pharmacology/Toxicology review by (b) (6), dated March 2, 2016. No preclinical data were submitted for this efficacy supplement. The reviewer's only recommendations were labeling changes. His comments were conveyed to the Sponsor.

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Per (b) (6) review, the supplement is approvable from a Pharmacology/Toxicology standpoint.

#### 4.4 Clinical Pharmacology

The Clinical Pharmacology review by (b) (6) concluded with the following recommendation:

“(b) (6), (b) (6) has reviewed the available clinical pharmacology information in relation to the newly proposed regimen for Mifeprrex®. We find the application to be acceptable from a Clinical Pharmacology perspective, provided that an agreement on the language in the package insert is reached between the Sponsor and the Division.”

No postmarketing commitments or requirement are recommended.

##### 4.4.1 Mechanism of Action

The original approved label states:

“The anti-progestational activity of mifepristone results from competitive interaction with progesterone at progesterone-receptor sites. Based on studies with various oral doses in several animal species (mouse, rat, rabbit, and monkey), the compound inhibits the activity of endogenous or exogenous progesterone. The termination of pregnancy results.

.....During pregnancy, the compound sensitizes the myometrium to the contraction-inducing activity of prostaglandins.”

##### 4.4.2 Pharmacodynamics

No new studies were submitted with this Application. See the original approved label.

##### 4.4.3 Pharmacokinetics

(b) (6) review states the following:

The pharmacokinetics (PK) of 200 mg mifepristone tablet has not been characterized in women. However, the PK data of 200 mg mifepristone tablet in men are available (1996 study): the mean maximum concentration ( $C_{max}$ ) ( $\pm$  standard error) = 1.77 ( $\pm$ 0.23) mg/L, the mean time to reach  $C_{max}$  ( $T_{max}$ ) = 0.81 ( $\pm$ 0.16) hour, and the mean area-under-the curve (AUC) = 25.8 ( $\pm$ 2.2) mg·h/L. While the effects of sex on the disposition of mifepristone have not been evaluated using Mifeprrex®, no sex differences in PK of mifepristone were seen with 300 mg mifepristone in a different NDA review (Korlym™, NDA 202107, Clinical Pharmacology review). Therefore, Section 12.3 of the proposed label in a PLR format should include the available PK data of mifepristone 200 mg tablet.

Cytochrome P450 3A4 (CYP3A4) plays an important role in the metabolism of mifepristone. Therefore, concomitant intake of CYP3A4 inducers with mifepristone

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is anticipated to have a significant effect on the disposition of mifepristone. However, the Sponsor did not conduct any *in vivo* studies to evaluate the effect of CYP3A4 inducers on the PK of Mifeprex®. Although the lowest effective therapeutic margin of mifepristone for termination of pregnancy has been not characterized clearly, the use of misoprostol in the regimen for Mifeprex® contributes to efficacy for inducing termination of pregnancy. In addition, concomitant intake of CYP3A4 inducers does not appear to affect the systemic exposure of misoprostol. In the proposed new regimen, another dose of misoprostol can be administered following day 7 to 14 of post-treatment of mifepristone if termination of pregnancy does not occur.

In summary, the contribution of misoprostol in termination of pregnancy and additional dosing option of misoprostol may compensate the possibly diminished efficacy of Mifeprex® in the users of CYP3A4 inducers. However, the labeling information should include the practical clinical guidance for the subject who has been exposed to CYP3A4 inducers.

**Reviewers comments:**

- **We agree with the Clinical Pharmacology conclusions and recommendations made by (b) (6).**
- **Within the last 10 years, administration of oral mifepristone followed by buccal misoprostol for early medical abortion has become the standard of care for MAB in many countries, including the US. This is based on 1) the PK profile of different doses and routes of administration for misoprostol, and 2) many clinical trials comparing the efficacy and safety of different dosing regimens.**

**From Chen and Creinin (2015)<sup>12</sup>:**

“With buccal administration, misoprostol is held in the buccal pouch between the teeth and gums for 30 minutes before swallowing any remaining tablets. Buccal misoprostol is slowly absorbed, unlike oral misoprostol, which is rapidly absorbed and undergoes extensive first-pass metabolism. After a dose of oral misoprostol, plasma misoprostol acid levels peak quickly at 30 minutes and decrease rapidly by 120 minutes. In contrast, after buccal administration, plasma misoprostol acid levels rise gradually to peak concentration after a median time of 75 minutes and fall slowly over several hours.”

<sup>12</sup> Chen MJ, Creinin MD. Mifepristone with Buccal Misoprostol for Medical Abortion Obstet Gynecol: a Systematic Review. *Obstet Gynecol* 2015;126(1):12-21.

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The PK profile of vaginal misoprostol is very similar to that of buccal misoprostol. These pharmacological differences between vaginal and buccal misoprostol do not have a clinically meaningful effect on the efficacy at different gestational weeks and the adverse event profile for the combination of mifepristone and misoprostol for early medical abortion. Those routes with rapid and significant absorption (e.g., sublingual) also have high efficacy (ACOG Bulletin<sup>1</sup>). This review, however, focuses primarily on the new dosing regimen proposed by the Applicant with some supportive data from studies that used vaginal and sublingual misoprostol.

## 5 Sources of Clinical Data

### 5.1 Tables of Studies/Clinical Trials

There were many studies that provided data for this NDA review. The original US trial that was reviewed for the Mifeprex approval in 2000 was performed over 20 years ago in 1994-95. Subsequently, there has been 20 years of experience with MAB, guidelines from professional organizations here and abroad, and clinical trials that have been published in the peer-reviewed medical literature. This review focuses on the information submitted by the Applicant for the change in the dosing regimen and follow-up.

For a complete list of all sources of information, see the extensive list of references in Appendix 9.6 at the end of this review.

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**Table 1: List of Major Studies Reviewed**

USA	International
Gatter 2015 <sup>13</sup> , retrospective	Louie 2014 <sup>14</sup> , Azerbaijan, prospective
Ireland 2015 <sup>15</sup> , retrospective	Ngoc 2014 <sup>16</sup> , Vietnam, prospective
Chong, 2015 <sup>17</sup> , prospective single-arm	Raymond 2013 <sup>18</sup> , International, including US, retrospective
Winikoff 2012 <sup>19</sup> , prospective	Goldstone 2012 <sup>20</sup> , Australia, retrospective
Perriera 2010 <sup>21</sup> , prospective	Boersma 2011 <sup>22</sup> , Curacao, prospective
Winikoff 2008 <sup>23</sup> , RCT*	Middleton 2005 <sup>24</sup> , prospective
Creinin 2007 <sup>25</sup> , prospective	Spitz 1998 <sup>26</sup> , single arm trial

<sup>13</sup> Gatter M, Cleland K, Nucatola DL. Efficacy and safety of medical abortion using mifepristone and buccal misoprostol through 63 days. Contraception 2015; 91:269-273.

<sup>14</sup> Louie KS, Tsereteli T, Chong E, Ailyeva F, Rzayeva G, Winikoff B. Acceptability and feasibility of mifepristone medical abortion in the early first trimester in Azerbaijan. Eur J Contracept Reprod Health Care 2014;19(6):457-464.

<sup>15</sup> Ireland LD, Gatter M, Chen AY. Medical compared with surgical abortion for effective pregnancy termination in the first trimester. Obstet Gynecol 2015;126:22-8.

<sup>16</sup> Ngoc NTN, et al. Acceptability and feasibility of phone follow-up after early medical abortion in Vietnam: A randomized controlled trial. Obstet Gynecol 2014;123:88-95.

<sup>17</sup> Chong E, Frye LJ, Castle J, Dean G, Kuehl L, Winikoff B. A prospective, non-randomized study of home use of mifepristone for medical abortion in the US. Contraception 2015;92:215-291.

<sup>18</sup> Raymond EG, et al. First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review. Contraception 2013;87(1):26-37.

<sup>19</sup> Winikoff B, Dzuba IG, Chong E, et al. Extending outpatient medical abortion services through 70 days of gestational age. Obstet Gynecol 2012;120:1070-6.

<sup>20</sup> Goldstone P, Michelson J, Williamson E. Early medical abortion using low-dose mifepristone followed by buccal misoprostol: A large Australian observational study. Med J Austral 2012; 197: 282-6.

<sup>21</sup> Perriera LK, Reeves MF, Chen BA, Hohmann HL, Hayes J, Creinin MD. Feasibility of telephone follow-up after medical abortion. Contraception 2010;81:143-149.

<sup>22</sup> Boersma AA, Meyboom-de Jong B, Kleiverda G. Mifepristone followed by home administration of buccal misoprostol for medical abortion up to 70 days of amenorrhoea in a general practice in Curacao. Eur J Contracept Reprod Health Care 2011;16:61-6.

<sup>23</sup> Winikoff B, Dzuba IG, Creinin MD, Crowden WA, Goldberg AB, Gonzales J, Howe M, Moskowitz J, Prine L, Shannon CS. Two distinct oral routes of misoprostol in mifepristone medical abortion: a randomized controlled trial. Obstet Gynecol 2008;112(6):1303-1310.

<sup>24</sup> Middleton T, et al. Randomized trial of mifepristone and buccal or vaginal misoprostol for abortion through 56 days of last menstrual period. Contraception 2005;72:328-32.

<sup>25</sup> Creinin MD, Schreiber CA, Bednarek P, Lintu H, Wagner MS, Meyn LA. Medical Abortion at the Same

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Source: compiled by clinical reviewers. \*Randomized controlled trial.

**Reviewer's comment:**

Table 1 above lists the major studies and review articles covering over 45,000 women who had an early MAB through 70 days gestation. Both retrospective and prospective studies were found to be valuable for this review. There are additional studies submitted by the Applicant that are not quoted or reviewed primarily because they did not use a dosing regimen relevant to that proposed by the Applicant or did not contain information pertinent to the other requested changes (e.g., less restrictive follow-up requirements or gestations through 70 days) in the NDA supplement. In some cases, studies that used variants of the proposed regimen were considered because PK, PD and clinical data indicate the relevance of data on vaginally-administered misoprostol, and because lower doses and certain other routes of administration of misoprostol are expected to have lower or similar levels of effectiveness.

### 5.1.1 Submissions during the Review Process

During the course of the review, the Applicant submitted additional supportive articles from the peer-reviewed medical literature, and provided more detailed data from previously submitted articles based on direct communication with the authors. Further, the Applicant submitted changes to some of the original proposals. Below in Table 2 is a list of the clinical submissions to the NDA after the initial submission dated May 18, 2015.

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Time (MAST Study Trial Group). Mifepristone and misoprostol administered simultaneously versus 24 hours apart for abortion a randomized controlled trial. *Obstet Gynecol* 2007;109:885-894.

<sup>26</sup> Spitz IM, et al. Early Pregnancy Termination with Mifepristone and Misoprostol in the United States. *NEJM* 1998;338(18):1241-47.

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**Table 2 Clinical Submissions during the Course of the Review**

Item	Submission Type, Date
Additional supportive articles	Amendment # 3, dated 9/23/2015
More detailed data from previously submitted articles	Amendment # 4, dated 10/13/2015 Amendment # 5, dated 11/16/2015 Amendment # 6, dated 12/8/2015
Additional supportive documents on patient counseling	Follow-up to 1/27/2016 teleconference, dated 2/2/2016
Additional supportive articles	Amendment # 8, dated 2/25/2016
<b>Proposed Additional Changes</b>	
REMS amendment, Revised REMS Supporting Document	Amendment # 2, dated 7/16/2015
Additional supportive articles	
REMS modification	Dated 11/4/2015
Labeling: (b) (4) Indication Statement	Amendment # 4, dated 10/13/2015
Labeling changes: (b) (4) the proposed new dosage regimen (b) (4)	Follow-up to 1/27/2016 teleconference, dated 2/15/2016, Also in Amendment # 9, dated 2/25/2016
Labeling: changes to Sections 2.4, 5.2, 6.1, 7, 8.1, 8.2, 8.6, 12.3, 14	Amendment # 7, dated 2/23/2016
Labeling changes: revise indication statement to state "through 70 days gestation	Amendment # 9, dated 2/25/2016
Labeling: changes to Sections 2.3, 6.1 and 14	Amendment # 10, dated 3/17/2016
REMS documents	Amendment #11, dated 3/21/2016

Source: Reviewer table.

## 5.2 Review Strategy

This is a joint review by two medical officers: (b) (6) reviewed the efficacy data and (b) (6) reviewed safety data and related issues. Other sections are jointly completed.

Within the last 10 years, use of buccal misoprostol with mifepristone for MAB has become commonplace. However, the published literature did not contain abundant information about medical abortion outcomes with buccal misoprostol at the time of the

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original NDA review. In this review, we summarize clinical outcomes and adverse effects of medical abortion regimens consisting of oral mifepristone 200 mg followed in 24-48 hours by buccal misoprostol 800 mcg in pregnancies through 70 days of gestation.

### 5.2.1 Discussion of Individual Studies/Clinical Trials

Information and findings from individual clinical trials and reviews in the published medical literature, websites, the Applicant and other sources are discussed in different sections throughout this review. As acknowledged during pre-submission discussions between the Applicant and (b) (6) and as is typical for literature-based submissions, original datasets from the trials that are cited were not available for submission in this supplement.

## 6 Review of Efficacy

### Efficacy Summary

**This summary lists the final conclusions based on review of the data. Not all of the conclusions, regarding covariates such as ethnicity, parity, previous abortion, are specifically addressed in labeling, but the reviewers believe that it is important to show that we evaluated many different aspects and potential risk factors for safe and effective MAB:**

- Medical termination of pregnancies through 70 days gestation is safe and effective and should be approved using the new proposed regimen.
- The original approved dosing regimen remains safe and effective but the new proposed dosing regimen is effective and should be approved for use in gestations through 70 days (10 weeks) gestation.
- 2015 Chen-Creinin review<sup>12</sup> of over 33,800 MABs concluded that regimens with a 24-hour time interval between mifepristone and buccal misoprostol administration are slightly less effective (94.2% success) compared to those with a 24-48-hour interval (96.8% success).
- 2013 Raymond review<sup>18</sup> of over 45,500 MABs using oral mifepristone 200 mg and various misoprostol doses concluded that the effectiveness decreases when:
  - misoprostol is taken orally compared to the three other routes of administration (buccal, sublingual, or vaginal)
  - the gestational age increases
  - the mifepristone-misoprostol interval is less than 24 hours
  - the total misoprostol dose is 400 mcg or less
- Efficacy in the adolescent population is the same or slightly better compared to non-adolescent women.

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- Efficacy outcomes do not appear to be related to other baseline characteristics including age, race, body weight, gravidity and previous spontaneous abortions. (Spitz data<sup>26</sup> and many subsequent studies)
- Data from the original US trial (1994-95; Spitz 1998<sup>26</sup>) showed lower efficacy rates with the originally approved Mifeprex dosing than is reported in a large number of subsequent trials using different mifepristone-misoprostol dosing regimens for early MAB. There does not appear to be any change in the safety profile.
- Raymond (2013 systematic review<sup>18</sup>) found no significant association between abortion failure rates and the timing of the follow-up evaluation.
- Over 30% of women will completely expel the products of conception within 4-5 hours of taking the misoprostol for MAB with gestations of 57-70 days (Winikoff 2012<sup>19</sup>); this finding supports the proposal to allow women to choose the timing of (within the labeled range) and where to take the misoprostol.
  - Data from the original NDA review showed occurrence of a successful (complete) MAB occurred in ≤ 4 hours after misoprostol administration in 45-46% of women up to 56 days gestation and 34.9% of women at 57-63 days gestation.
- Home administration of misoprostol is efficacious, practical, and safe (see Safety Section)

**Reviewer's overall comment:**

**Compared to the current Mifeprex approved label and regimen, the Applicant has requested less restrictive measures for location and timing of misoprostol administration and follow-up measures for early MAB. We believe that a regimen that includes these less restrictive measures is equally safe and effective, while offering women greater convenience and providing a less burdensome procedure for patients and providers.**

**6.1 Indication**

In the initial submission of this efficacy supplement, the proposed new indication was the following: "Mifeprrex is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy [REDACTED] (b) (4)" In Amendment # 9, submitted on February 25, 2016, the Applicant proposed [REDACTED] (b) (4) the gestational age through 70 days.

The proposed new modified regimen uses buccal (not oral) misoprostol administered 24-48 hours after taking a lower dose, 200 mg instead of 600mg, of oral mifepristone. The labeled dose of misoprostol is increased compared to the current approved regimen, from 400 mcg to 800 mcg. [REDACTED] (b) (4)

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(b) (4)

These requests were thoroughly reviewed by the Agency and we believe the product is safe and effective for the indication, which reads:

“Mifepr is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation.”

### **6.1.1 Methods**

There were numerous articles from the peer-reviewed medical literature that were submitted by the Applicant. Articles were also cited in three letters sent to CDER Center Director Janet Woodcock, MD from 1) ACOG, 2) a group of academic professionals and women's health non-profit organizations, and 3) thirty professional and academic organizations, all of which requested changes to the Mifepr labeling and REMS. All relevant publications cited in those three letters were also submitted by the Applicant for our review. The articles and sources of data used for this review are listed in the Reference List in Appendix 9.6 at the end of this review.

The various studies noted in the articles had slightly different designs, inclusion criteria, dosing regimens and endpoints for safety and efficacy. The review focus is on clinical trials and follow-up methods for early medical abortion, including gestations through 70 days (10 weeks).

### **6.1.2 Demographics**

Many of the trials were randomized and some were blinded to the actual dose of the two drugs that were administered. The route of misoprostol administration could not be easily blinded. Although there may have been some small differences in the demographic data for the different arms, it is doubtful that demographic differences such as race or ethnicity are clinically meaningful in relation to the safety and efficacy of medical abortion.

### **6.1.3 Subject Disposition**

Most of the studies noted the number of women who were lost to follow-up and did not count them in the efficacy analysis. All women with any available safety data were included in the safety analyses. See Safety Section for further discussion.

### **6.1.4 Analysis of Primary Endpoint(s)**

The studies analyzed for data used in this NDA review almost universally defined their primary efficacy endpoint as expulsion of the pregnancy from the uterus without need for any surgical evacuation or procedure for any reason (including patient request).

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**6.1.5 Analysis of Secondary Endpoints(s)**

In addition to the final outcome of MAB success or lack of success (i.e., surgical or medical intervention needed), there are intermediate outcomes:

- Incomplete abortion: pregnancy no longer ongoing, but only partial or non-expulsion of the products of conception has occurred
- Ongoing pregnancy based on fetal heartbeat and/or growth

In the case of incomplete expulsion but where the pregnancy is no longer ongoing, there are in the US several safe options available to the healthcare provider and the patient:

- Expectant management (in many cases, complete expulsion will occur spontaneously given additional time)
- Additional dose of misoprostol
- Minor surgical procedure such as a vacuum aspiration in the clinic/office
- Surgical procedure under anesthesia such as a dilation and curettage (D&C)

For ongoing pregnancies following the initial MAB procedure, typically one of the surgical procedures is performed.

In addition to these two intermediate outcomes, there are other cases in which a surgical intervention might be performed:

- Intervention because of bleeding or other aspect of the patient's condition: the healthcare provider judges that surgical intervention is indicated
- Patient request: the patient requests surgical intervention for any reason

**6.1.6 Proposal for a New Dosing Regimen**

There are five major changes proposed by the Applicant in this supplement for which efficacy data will be discussed. The changes are interrelated and, in general, the same studies usually provide evidence to support multiple changes, although data from a given study may be more or less pertinent to a specific change (e.g., extending the approved gestational age, home administration of buccal misoprostol, etc.).

**Summary of changes to dosing regimen, indication, and follow-up initially requested by the Applicant in the NDA Supplement:**

1. **Addition of a new dosing regimen of Mifepr 200 mg orally followed by the buccal administration of 800 mcg misoprostol at 24-48 hours instead of 48 hours**
2. **Increase in gestational age from** (b) (4)
3. **Option to administer misoprostol outside of the clinic**

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4. **Option that a repeat dose of misoprostol may be used if needed for women using the new proposed dosing regimen**
5. **Follow-up timing and methods: follow-up is needed at 7-14 days after Mifeprex administration; the specific nature and timing of the follow-up to be agreed upon by the (b) (4) and patient. The current approved label states: "Patients will return for a follow-up visit approximately 14 days after the administration of Mifeprex."**

Discussion and analysis of the data supporting the five changes follows in five individual sections.

1. **Proposal of a new dosing regimen that:**

- 1) **decreases the oral dose of Mifeprex from 600 mg to 200 mg orally,**
- 2) **increases the misoprostol dose from 400 mcg orally to 800 mcg misoprostol administered buccally, and**
- 3) **revises the interval between Mifeprex and misoprostol dosing from 48 hours to "24-48 hours."**

(b) (4)

Background on some dosing data and US practices:

There is ample medical evidence that the currently approved dose regimen (oral mifepristone 600 mg followed 2 days later with oral misoprostol 400 mcg) is safe and efficacious up to 49 days gestation. It was approved in September 2000 based on the US clinical trial of 1994-95 and two French trials. After 1995, however, more studies gradually became available using lower doses of mifepristone and different doses and routes of administration for misoprostol. These newer data were not submitted to or considered in the original NDA review. Studies also showed that with lower doses (< 600 mg) of oral mifepristone followed by oral misoprostol 400 mcg, the treatment success rate is greater than 95% up to 49 days gestation.

It is difficult to tell how many MABs in the US actually used the FDA-approved dosing regimen following the 2000 approval. It is clear that many clinics and individual practitioners did not. For example, from 2001 to March 2006, Planned Parenthood Federation of America (PPFA) health centers throughout the United States provided medical abortions principally using a regimen of oral mifepristone 200 mg, followed 24–48 hours later by 800 mcg misoprostol administered vaginally at home.<sup>27</sup> Of note, PPFA has been and continues to be the largest provider of MAB services in the US.

<sup>27</sup> Fjerstad M, Sivin I, Lichtenberg ES, Trussell J, Cleland K, Cullins V. Effectiveness of medical abortion

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**Reviewer's comment:**

The 2009 Fjerstad article<sup>28</sup> states that PPFA was a federation of 97 independent local affiliates operating 880 health centers throughout the US; roughly 300 of those centers provided medical abortion. So, within one year of the FDA Mifeprex approval, PPFA was using a dosing regimen (actual doses and routes of administration) very similar to that proposed in this efficacy supplement.

Meanwhile, from September 2003 to June 2005, there were four fatalities in the US and one in August 2001 in a Canadian clinical trial, all due to a sudden and rapid sepsis secondary to the bacteria *Clostridium sordellii*. The five cases were with early MAB (all around 7 weeks gestation) in women who had used 800 mcg vaginal misoprostol. By late March 2006, consideration of these fatal uterine infections led PPFA to 1) change the route of administration of the 800 mcg misoprostol from vaginal to buccal (or, much less commonly, oral) and 2) employ additional measures (sexually transmitted infection [STI] testing and treatment if positive, or use of prophylactic antibiotics) to minimize the risk of subsequent serious uterine infections. In July 2007, PPFA began requiring<sup>28</sup> routine treatment with antibiotics for all medical abortions at their health centers.<sup>28</sup>

**Reviewer's comment:**

As stated in currently approved labeling “No causal relationship between the use of Mifepr and misoprostol and these events [serious and sometimes fatal infections and bleeding] has been established.” There is no clear evidence that the vaginal use of misoprostol causes infection, and no causal association has been identified between the cases of sepsis and vaginal administration of misoprostol. While labeling was revised in November 2004 and July 2005 to recommend that providers have a high index of suspicion in order to rule out serious infection and sepsis, the Agency did not consider there was sufficient evidence to justify recommending prophylactic antibiotics.

A 2006 article showed that in pregnancies greater than 49 days gestation, compared to oral administration of misoprostol, the bioavailability and efficacy with use of misoprostol is increased by vaginal, sublingual and buccal administration, avoiding first-pass metabolism by the liver.<sup>29</sup> Furthermore, a 2009 review of MAB<sup>30</sup> noted that:

“Consistent with other kinetic studies, clinical trials have demonstrated no change in efficacy when mifepristone doses are reduced from 600 to 200 mg. Multiple

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with mifepristone and buccal misoprostol through 59 gestational days. Contraception 2009;80:282-6.

<sup>28</sup> Fjerstad M, Trussell J, et al. Rates of serious infection after changes in regimens for medical abortion. NEJM 2009;361:145-51.

<sup>29</sup> Fiala C, Gemzell-Danielsson K. Review of medical abortion using mifepristone in combination with prostaglandin analogue. Contraception 2006;74:66-86.

<sup>30</sup> Bartz B, Goldberg A. Medical Abortion. Clin Obstet and Gyn 2009; 52:140-50.

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clinical studies, including a 2004 Cochrane meta-analysis, reported that a regimen of 200 mg of oral mifepristone followed 24 to 48 hours later by 800 mcg of vaginal misoprostol results in complete abortion in 96% of cases at gestations of up to 63 days and that increasing the mifepristone dose to 600 mg does not improve efficacy.”

In a 2010 review article covering 25 years of the clinical development of mifepristone followed by a prostaglandin for MAB, Spitz<sup>31</sup> noted similar conclusions:

“In the US, most investigators administer 200 mg rather than 600 mg mifepristone as many trials have shown equivalent results with these two dose schedules. A recent meta-analysis of four randomized controlled trials compared the two dose regimens. Endpoints were complete abortion, continuing pregnancy and side effects. The two doses [600 v. 200 mg mifepristone] result in similar rates of complete abortion with no difference in adverse events.”

Another change in clinical practice was related to the labeling stipulation that women return to the clinic/office two days after Mifeprex was administered to take the misoprostol dose. Many experts involved with termination of early pregnancies also advocated misoprostol self-administration at home to mitigate the time, travel and inconvenience of this additional visit.

In the US, the American College of Obstetricians and Gynecologists (ACOG), National Abortion Federation<sup>32</sup>, and PPFA currently all endorse the lower oral dose of mifepristone followed in 24-48 hours with misoprostol. According to the 2014 ACOG Practice Bulletin, the misoprostol route of administration may be oral, buccal, sublingual or vaginal; sublingual administration, however, has a more rapid absorption resulting in a higher incidence of adverse side effects.<sup>1</sup>

#### European practice:

In December 2011, the International Federation of Obstetrics and Gynaecology (FIGO) published revised guidelines for the use of mifepristone and misoprostol for MAB up to 63 days, 64-84 days, and after 84 days (12 weeks) gestation.<sup>33</sup> The FIGO recommended regimens using 200 mg of oral mifepristone followed by 800 mcg of misoprostol administered vaginally, buccally, or sublingually. Up to 57-63 days gestational age, misoprostol is taken 24-48 hours after mifepristone. Per the review of data available to them, FIGO decided additional doses of 400 mcg misoprostol may be

<sup>31</sup> Spitz IM. Mifepristone: where do we come from and where are we going? Clinical development over a quarter of a century. *Contraception* 2010;82:442–52.

<sup>32</sup> National Abortion Federation Guidelines 2015.

<sup>33</sup> Faundes A. The combination of mifepristone and misoprostol for the termination of pregnancy. *Int J Gynecol Obstet* 2011;115:1-4.

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safely used depending on gestational age, and these combinations result in a complete termination in more than 95% of cases.

Similar guidelines using either vaginal, buccal, or sublingual misoprostol are endorsed by the World Health Organization (WHO), the United Kingdom Royal College of Obstetricians and Gynecologists<sup>34</sup>, and a recent Cochrane Review (2011, Issue11).<sup>35</sup>

**Reviewer's Comment:**

**From the above discussion, it is clear that the standard of care in the US for early MAB has deviated from the FDA-approved dosing regimen. PPFA provides the largest number of medical abortions each year in the US and as early as 2001, was already using the regimen of 200 mg oral mifepristone followed 24-48 hours later by 800 mcg vaginal misoprostol.**

There are a large number of studies and reviews that support the efficacy of the proposed new dose regimen through 63-70 days gestation. Efficacy was defined in these studies as a complete expulsion of the pregnancy without need for surgical intervention for any reason during the follow up period. The 2015 review by Chen and Creinin summarized clinical outcomes and adverse effects from 20 MAB studies including a total of 33,846 women using regimens consisting of 200 mg oral mifepristone followed by buccal misoprostol through 70 days gestation. All studies except two used 800 mcg misoprostol. Two studies (827 women) used 400 mcg buccal misoprostol. Six studies used a 24-hour time interval between mifepristone and buccal misoprostol administration and 14 used a 24-48 hour window for the dosing interval. The table below lists the 15 studies using the proposed doses (200 mg plus 800 mcg) with a 24-48 hour dosing interval.

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<sup>34</sup> Royal College of Obstetricians and Gynaecologists. The care of women requesting induced abortion: evidence-based clinical guideline Number 7. 3rd ed. London (UK):RCOG Press 2011.

<sup>35</sup> Kulier R, Kapp N, et al. Medical methods for first trimester abortion (Review). The Cochrane Library 2011, Issue 11:1-126.

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**Table 3: Efficacy- Mifepristone 200 mg with Buccal Misoprostol 800 mcg 24-48 Hours Later - US Studies**

Study &Year	Design, Location	Gestation (maximum days)	M-M Interval (hrs)	Evaluable Subjects (N)	Success - no intervention (%)
<b>Middleton 2005<sup>24</sup> US</b>	<b>Prospective</b>	56	24-48	216	94.9
<b>Winikoff 2008<sup>23</sup> US</b>	<b>Prospective</b>	63	24-36	421	96.2
<b>Fjerstad 2009<sup>27</sup> US</b>	<b>Retrospective</b>	59	24-48	1,349	98.3
<b>Grossman 2011<sup>36</sup> US - Clinic Mife v. Tele-med</b>	<b>Prospective</b>	63	24-48	449	Clinic: 96.9% Telemed: 98.7%
<b>Winikoff 2012<sup>19</sup> US</b>	<b>Prospective</b>	57-70	24-48	629	93.2
<b>Gatter 2015<sup>13</sup> US</b>	<b>Retrospective</b>	63	24-48	13,373	97.7
<b>Chong 2015<sup>17</sup> US</b>	<b>Prospective</b>	63	24-48	357	96.7
<b>TOTALS</b>	<b>7 Studies</b>	<b>56-70 days</b>	<b>24-48 hr</b>	<b>16,794</b>	<b>97.4</b>

Source: Modified from Table 3, page 14-15, Chen-Creinin 2015 Review and submitted articles. All subjects had 200 mg oral mifepristone followed by 800 mcg buccal misoprostol.

Success percentages calculated by clinical reviewer.

<sup>36</sup> Grossman D, Grindlay K, Buchacker T, Lane K, Blanchard K. Effectiveness and acceptability of medical abortion provided thorough telemedicine. Obstet Gynecol 2011;118:296-303.

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**Table 4: Efficacy- Mifepristone 200 mg with Buccal Misoprostol 800 mcg 24-48 Hours Later- Non- US Studies**

Study &Year/Country	Design, Location	Gestation (maximum)	M-M Interval (hrs)	Evaluable Subjects (N)	Success - no intervention (%)
Alam 2013 <sup>37</sup> Bangladesh	Prospective	63	24	629	92.7
Blum 2012 <sup>70</sup>	Prospective	63	24	210	92.9
Boersma 2011 <sup>22</sup> Curacao	Prospective	70	24-48	307	97.7
Chai 2013 <sup>38</sup> Hong Kong	Prospective	63	48	45	95.6
Dahiya 2012 <sup>39</sup> India	Prospective	50	24	50	92
Chong 2012 <sup>40</sup> Georgia, Vietnam	Prospective	63	36-48	560	96.4
Giri 2011 <sup>41</sup> Nepal	Prospective	63	24	95	93.6
Goldstone 2012 <sup>20</sup> Australia	Retrospective	63	24-48	11,155	96.5
Louie 2014 <sup>14</sup> Azerbaijan	Prospective	63	24-48	863	97.3
Ngo 2012 <sup>42</sup> China	Retrospective	63	36-48	167	91.0
Ngoc 2011 <sup>43</sup> Vietnam	Prospective	63	24	201	96.5
Ngoc 2014 <sup>16</sup> Vietnam	Prospective	63	24-48	1,371	94.7
Olavarietta 2015 <sup>85</sup> Mexico	Prospective	70	24	884	98.2
Pena 2014 <sup>44</sup> Mexico	Prospective	70	24-48	971	97.3

<sup>37</sup> Alam A, Bracken H et al. Acceptability and Feasibility of Mifepristone-Misoprostol for Menstrual Regulation in Bangladesh. International Persp on Sexual and Reprod Health 2013;39(2):79-87.

<sup>38</sup> Chai J, Wong CY, Ho PC. A randomized clinical trial comparing the short-term side effects of sublingual and buccal routes of misoprostol administration for medical abortions up to 63 days' gestation. Contraception 2013;87:480-5.

<sup>39</sup> Dahiya K, Ahuja K, Dhingra A et al. Efficacy and safety of mifepristone and buccal misoprostol versus buccal misoprostol alone for medical abortion. Arch Gynecol Obstet 2012; 285: 1055-8

<sup>40</sup> Chong E, Tsereteli T, Nguyen NN, Winikoff B. A randomized controlled trial of different buccal misoprostol doses in mifepristone medical abortion. Contraception 2012;86:251-6.

<sup>41</sup> Giri A, Tuladhar H et al. Prospective study of medical abortion in Nepal Medical College- a one year experience. Nepal Medical Coll J 2011;13(3):213-15.

<sup>42</sup> Ngo TD, Park MH, Xiao Y. Comparing the WHO versus China recommended protocol for first trimester medical abortion: a retrospective analysis. Int J Womens Health 2012;4:123-7.

<sup>43</sup> Ngoc NTN, et al. Comparing two early medical abortion regimens: mifepristone+misoprostol vs. misoprostol alone. Contraception 2011;83:410-17.

<sup>44</sup> Pena M, Dzuba IG, Smith PS, et al. Efficacy and acceptability of a mifepristone-misoprostol combined

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<b>Sanhueza 2015<sup>48</sup> Mexico</b>	<b>Prospective</b>	<b>70</b>	<b>24-48</b>	<b>896</b>	<b>93.3</b>
<b>TOTALS</b>	<b>15 Studies</b>	<b>56-70 days</b>	<b>24-48 hrs</b>	<b>18,425</b>	<b>96.1%</b>

**Source:** Modified from Table 3, page 14-15, Chen-Creinin 2015 Review and submitted articles. All subjects had 200 mg oral mifepristone followed by 800 mcg buccal misoprostol.

Success percentages calculated by clinical reviewer.

**Reviewer's comments:**

The data above in Table 3 and Table 4 from ~16,800 US women and ~18,400 non-US women in clinical studies of MAB through 70 days gestation with success rates of 97.4% (US) and 96.1% (non-US) strongly support the proposed new dosing regimen and the extension of the acceptable gestational age. The number of US and non-US studies, the number of evaluable women, and the overall complete abortion rates (termination with no surgical intervention) will be described in the efficacy table in Section 14 CLINICAL STUDIES in the new approved label. Additional discussion on increasing the gestational age through 70 days follows in the next major section.

Precise timing of the administration of misoprostol has not been shown to result in a higher success rate which is why the majority of the above studies allowed a range of hours between the mifepristone dose and misoprostol dose rather than one set time between the two drugs. The 2013 Raymond systematic review<sup>18</sup> of 87 studies that exclusively used a mifepristone 200 mg oral dose in over 45,000 women, followed by varying doses and routes of administration of misoprostol, concluded that if the mifepristone-misoprostol interval is < 24 hours, the procedure is less effective compared to an interval of 24-48 hours.

Another study<sup>45</sup> also looked at the question of the mifepristone-misoprostol interval. The authors conducted a systematic review of randomized controlled trials published from 1999 to 2008 to assess the evidence for a shorter mifepristone and misoprostol administration interval for first trimester medical termination. Searching strategy included MEDLINE, EMBASE, CLINAHL and Cochrane Library. The primary outcome measure was complete abortion without the need for a surgical procedure. "Five randomized controlled trials (RCTs) compared the efficacy of mifepristone-misoprostol administration intervals between 0 and 72 hours in 5,139 participants. The complete abortion rates varied between 90% and 98%. Although the meta-analysis of pooled data of all five RCTs showed no statistically significant difference in efficacy between

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regimen for early induced abortion among women in Mexico City. Int J Gynaecol Obstet 2014;127:82-5.

<sup>45</sup> Wedisinghe L and Elsandabesee D. Flexible mifepristone and misoprostol administration interval for first-trimester medical termination. *Contraception* 2010;81(4):269-74. doi: 10.1016/j.contraception.2009.09.007. Epub Oct 29, 2009.

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the shorter and longer dosing intervals, there was a trend toward slightly lower success rates with administration intervals < 8 hours." This study supports the finding that the proposed regimen is effective with the 24-48 hour flexible interval. Labeling will indicate that the regimen may not work as well if the misoprostol is taken earlier than 24 hours after Mifeprex.

**Reviewer's Final Recommendation:**

**The new proposed regimen of 200 mg oral mifepristone followed in 24-48 hours with 800 mcg buccal misoprostol should be approved; there are sufficient data from the medical literature with over 35,000 women supporting the regimen's efficacy (termination without any additional surgical intervention) as being in the 91-98% range.**

**6.1.7 Increase in gestational age from 49 days to 70 days****Original NDA review:**

The US clinical trial<sup>31</sup> was conducted from September 1994 to September 1995 and treated 2,121 women. A total of 2,015 women (95%) returned at the 14-day follow-up visit. The trial categorized women into three groups based on gestational age at the time of procedure, and evaluated the rates of "Success" (a complete pregnancy termination without use of any additional doses of misoprostol or surgical intervention), and the rates of "Failure" (with four sub-categories of incomplete abortion, ongoing pregnancy, intervention for medical reason, and intervention solely because of patient request). The success and failure data are shown in Table 5.

**Table 5: Original NDA Efficacy Results**

OUTCOME	≤ 49 Days N= 827 (%)	50-56 Days N= 678 (%)	57-63 Days N= 510 (%)
Success (mifepristone + misoprostol)	762 (92)	563 (83)	395 (77)*†
<b>Failure (any surgical intervention for any reason) N (%)</b>			
Total failures	8%	17%	23%*†
Incomplete abortion	39 (5)	51 (8)‡	36 (7)
Ongoing pregnancy	8 (1)	25 (4)*	46 (9)* §
Medical indication for intervention	13 (2)	26 (4)‡	21 (4)‡
Patient's request for intervention	5 (0.6)	13 (2)	12 (2)‡

\*P&lt;0.001 for the comparison with the ≤ 49-days group.

†P= 0.02 for the comparison with the 50 to 56-days group.

‡ 0.001 ≤ P&lt;0.03 for the comparison with the ≤ 49-days group.

§ P&lt;0.001 for the comparison with the 50 to 56-days group.

Source: Modified from Table 1, pg 1243 in the Spitz NEJM article (1998).

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**Reviewer's comments:**

Looking at the results in the table above, it is reasonable that the approved use was only for women in the first 49 days' gestation, given the 8% "failure rate" in this subgroup, compared to 17% and 23% failure rates for the longer gestations. It is important to note that failure was defined as any case requiring surgical intervention for any of the following reasons:

- incomplete abortion (incomplete expulsion)
- documented ongoing pregnancy
- medical reasons (usually heavy vaginal bleeding with or without retained products of conception)
- patient request (usually for bleeding)

As has been pointed out, since the US trial data used for the FDA approval of Mifeprex, given the experience and data gained in the last 20 years from millions of women in the US and abroad, the success rates and overall outcomes are very different. Currently, when a "failure" occurs, using the original definition, options that are now commonly available include the following:

- expectant management (wait and see) in the case of an incomplete abortion (i.e., pregnancy terminated but not fully expelled)\*
- medical treatment for bleeding, pain and other common symptoms
- clinical evaluation with the use of 1) office ultrasound and/or 2) hCG data determined by rapid, sensitive urine and/or serum testing\*
- additional doses of misoprostol for an incomplete abortion\*
- less invasive surgical intervention (vacuum aspiration) in the clinic/office instead of a D&C under anesthesia in an operating room
- continuing the pregnancy (although the medical recommendation is to proceed to a surgical abortion in such a case, we acknowledge that a woman could potentially decide to continue the pregnancy)

\* per protocol, these options were NOT available in the original US trial

It is also evident that the proposed new dosing regimen is considerably more effective for all gestations through 70 days [see data and discussion that follows for 57-63 and 64-70 days gestation], especially when compared to the original data using the FDA-approved regimen which had "success" rates of only 83% and 77% at 50-56 and 57-63 days gestation, respectively.

**Current evidence for increasing the gestational age to 70 days**

Current evidence demonstrates that the new proposed medical abortion regimen is effective for women in the range of 57-63 days and 64-70 days of gestation. A 2015

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systematic review identified six published studies that recorded data on outcomes of medical abortions performed during gestational Days 64-70.<sup>46</sup>

The published studies were conducted in the United States, UK, Mexico, Curaçao, Vietnam, and the Republic of Georgia. All subjects were treated as outpatients between 2007 and 2015. The older UK study evaluated 127 women who were at 64-70 days gestation and treated with 200 mg oral mifepristone followed by 800 mcg vaginal misoprostol.<sup>47</sup>

**Reviewer comment:**

**We evaluated the data separately for 57-63 and 64-70 days of gestation. The following two tables show the efficacy data for 57-63 and 64-70 days gestation (also known as Week 9 and Week 10).**

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<sup>46</sup> Abbas D, Chong E, Raymond EG. Outpatient medical abortion is safe and effective through 70days gestation. Contraception 2015;92:197-9.

<sup>47</sup> Gouk EV, et al. Medical termination of pregnancy at 63-83 days gestation. British J Obstet Gyn 1999;106:535-539.

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**Table 6: MAB Efficacy Outcome 57-63 Days Gestation**

Study	Enrolled N	Followed N	Success N (%)	Ongoing Pregnancy N (%)	Lost to Follow up %	Comment
Winikoff <sup>23</sup> 2008 US-	132	115	109 (94.8)	2 (1.7)	13.0%	* Proposed Dosing
Winikoff <sup>19</sup> 2012 US	379	325	304 (93.5)	10 (3.1)	14.2%	* Proposed Dosing
Gatter <sup>13</sup> 2015 US	1527	1286	1228 (95.5)	21 (1.6)	15.8%	* Proposed Dosing
Sanhueza <sup>48</sup> 2015 Mexico City	196	190	171 (90.0)	6 (3.2)	3.1%	* Proposed dosing
Boersma <sup>22</sup> 2011** Curacao	105	95	91 (95.8)	2 (2.1)	9.5%	*Proposed dosing @ 24-36 hr @ home
Pena <sup>44</sup> 2014 Mexico City	177	171	164 (95.9)	2 (1.2)	3.4%	* Proposed dosing
Chong <sup>40</sup> 2012 Viet Nam, Georgia	86	85	79 (92.9)	2 (2.4)	1.2%	*Proposed dosing 36-48 hr
	81	81	77 (95.1)	2 (2.5)	0%	400 mcg buccal @ 36-48 hr
Bracken <sup>49</sup> 2014 4 countries-	389	382	362 (94.8)	7 (1.8)	1.3% (2 women withdrew)	400 mcg sublingual @ 24-48 hr
<b>TOTAL</b>	<b>3,072</b>	<b>2,730</b>	<b>2,585 (94.7)</b>	<b>54 (2.0%)</b>	<b>11.1%</b>	

\*Mifepristone oral 200 mg followed in 24-48 hour range with misoprostol buccal 800 mcg.

\*\*Boersma study reported the interval from 50-63 days without further breakdown.

Source: Data from published studies.

<sup>48</sup> Sanhueza Smith P, Pena M, Dzuba IG, et al. Safety, efficacy and acceptability of outpatient mifepristone-misoprostol medical abortion through 70 days since last menstrual period in public sector facilities in Mexico City. Reprod Health Matters 2015;22:75-82.

<sup>49</sup> Bracken H, Dabash R, Tservadze G et al. A two-pill sublingual misoprostol outpatient regimen following mifepristone for medical abortion through 70 days' LMP: a prospective comparative open-label trial. Contraception 2014;89(3):181-6.

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**Reviewer comments:**

Although the Chong and Bracken studies do not use the exact proposed dosing regimen, it is felt that their efficacy results are relevant because both used a lower dose of misoprostol, which, if anything, would have been expected to provide lower efficacy.

After careful review of the above eight studies, we find the following results. A combined total of 3,072 women were treated at 57-63 days of gestation, with 2,730 (88.9%) providing outcome data. Of these women, 2,585 (94.7%) had a complete medical abortion (pregnancy termination without any surgical intervention), and 54 (2.0%) had ongoing pregnancies. This successful treatment rate is better (94.7% compared to 92.1%) than the rate in the data on which the 2000 FDA Mifeprex approval was based. The data are sufficient and acceptable for extending the approval of Mifeprex up to at least 63 days gestation.

The numbers here do not exactly match the results shown in the efficacy table for 57-63 gestational days that are in Section 14 CLINICAL STUDIES in the new approved label, which is limited to studies using the identical dosing regimen to that proposed in this supplement. The number of evaluable women here is higher because the Chong and Bracken data are included, as noted above in the comment. The label, however, states the same conclusion of a 94.7% complete medical abortion rate and a 2% ongoing pregnancy rate.

Data for 64-70 days gestation are found in the next table.

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Table 7: MAB Efficacy Outcome 64-70 Days Gestation

Study	Enrolled N	Followed N	Success N (%)	Ongoing Pregnancy N (%)	Lost to Follow up %	Comment
Winikoff <sup>19</sup> 2012	350	304	282 (92.8)	9 (3.0)	13.1	*Proposed dosing
Sanhueza <sup>48</sup> 2015	150	147	134 (91.2)	5 (3.4)	2.0	* Proposed dosing
Boersma <sup>22</sup> 2011†	26	26	25 (96.2)	1 (3.8)	0	Proposed dosing @ 24-36 hr @ home
Peña <sup>44</sup> 2014	2	2	2 (100)	0 (0)	0	* Proposed dosing
Chong <sup>40</sup> 2012 RCT	1	1	1 (100)	0 (0)	0	* Proposed dosing @ 36-48 hr
	6	6	6 (100)	0 (0)	0	400 mcg buccal
Y Gouk <sup>47</sup> 1999 UK- misoprostol in hospital	127	127	120 (94.5)	7 (5.5)	0	800 mcg vaginal @ 36-48 hr
Bracken <sup>49</sup> 2014	325	321	295 (91.9)	7 (2.2)	1.2	400 mcg sublingual @ 24-48 hr
<b>TOTAL</b>	<b>987</b>	<b>934</b>	<b>865 (92.6)</b>	<b>29/934 (3.1)</b>	<b>53/987 (5.4)</b>	

\*Mifepristone oral 200 mg followed in 24-48 hour range with misoprostol buccal 800 mcg.

Y The Gouk study in 1996-97 included 253 women at 63-83 days gestation (Weeks 10-12).

Source: Table modified with data from published studies. See Abbas D et al. Contraception [MAB through 70 days gestation] 92 (2015):197-199.

Reviewer comments:

Use of the Chong and Bracken data is discussed above. Although the Gouk regimen used a different route of administration for misoprostol, the effectiveness of the vaginal route appears to be similar to that of the buccal route; therefore, these data are considered relevant. Data on sublingual administration of misoprostol may be less generalizable due to the different pharmacokinetic (PK) profile and higher AE frequency compared to buccal

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administration. Also, see Section 4.4.3 Pharmacokinetics and the Cross Discipline Team Leader review.

The abortion success rates shown above from seven studies are comparable to (and in several studies, greater than) the success rates for medical abortion in the initial 2000 decision for Mifeprax up to 49 days gestation. The proportion of subjects with complete success without any medical or surgical intervention in the US pivotal trial that supported the original approval was 92.1%, as shown in Table 5, in 827 women encompassing all gestational weeks up to 49 days. The data in the above two tables include 3,072 women treated at 57-63 days gestation and 987 women at 64-70 days gestation. We believe that this comprises a sufficient number of women in each gestational week upon which to make a clinical decision, and that the overall 94.7% and 92.6% success rates are acceptable for approval.

The data here clearly establish the efficacy of medical abortion with mifepristone and misoprostol through 70 days gestation. At least two Gynuity Health studies of outpatient medical abortion through 70 days are ongoing, so more information from clinical studies will be available in the future.

It is also worth noting that in November 2015, the National Medical Committee of PPFA approved medical abortion through 70 days, so this is currently their standard of care.

**Reviewer's Final Recommendation:**

**The new proposed regimen of 200 mg oral mifepristone followed in 24-48 hours with 800 mcg buccal misoprostol should be approved for use through 70 days gestation (10 weeks from the first day of the LMP).**

### 6.1.8 At-home Administration of Misoprostol

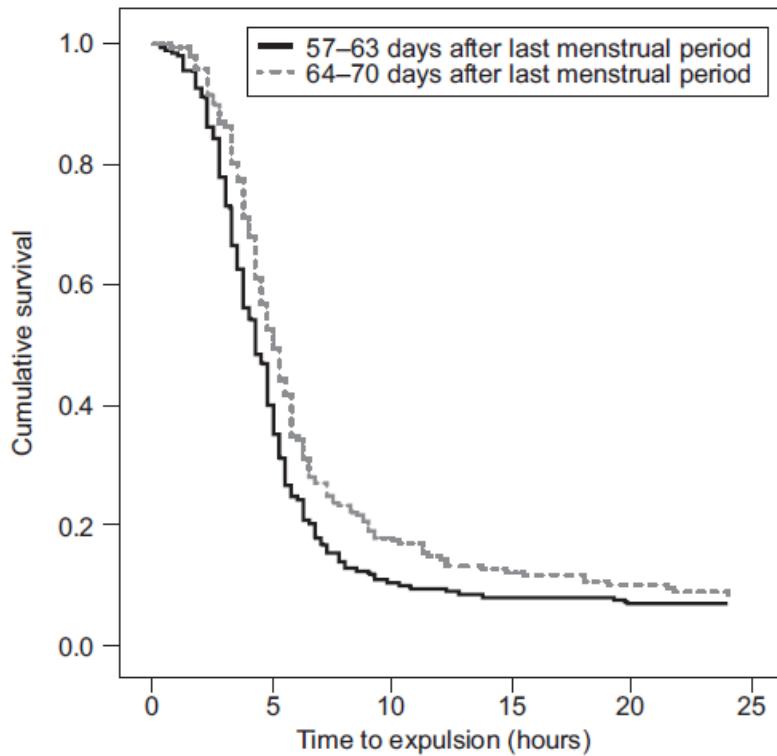
For the majority of women, the most significant cramping and bleeding will occur within 2-24 hours after taking misoprostol. Requiring women to take misoprostol in the office necessitates another visit and can interfere with the woman's ability to make reasonable plans for the expected bleeding and cramping. With the option to take misoprostol at home the woman can:

- **Plan to experience cramping and bleeding at a safe and convenient time when support is available**
- **Minimize loss of income (for childcare or missed days of work)**
- **Experience improved comfort, satisfaction and privacy**

Data (graph below) from Winikoff (2012)<sup>19</sup> shows the time in hours to complete expulsion of the pregnancy after misoprostol administration for gestations at 57-63 and 64-70 days. Within about 5 hours after misoprostol dosing, 50-60% of the MABs are complete.

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Many studies have recorded data on home use in the US and elsewhere and “demonstrated that 87-97% of women find home use of misoprostol acceptable. Home use of misoprostol is now standard in the US.”<sup>50</sup> The 2009-10 Swica comparative study focused on the option to take both mifepristone and misoprostol at home after being counseled at the office/clinic. There was no significant difference in either efficacy or safety for the 139 women (46%) who took both medications at home compared to 161 women who took mifepristone in the office and misoprostol at home.

Table 8 that follows is a list of studies where data are available on home use of misoprostol and the specific efficacy findings.

<sup>50</sup> Swica Y, et al. Acceptability of home use of mifepristone for medical abortion. Contraception 2013;88:122-127.

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**Table 8: Misoprostol Self-administration at Home**

Study	Evaluable N	Misoprostol at home	Success	Comment
<b>US Studies</b>				
Gatter 2015 <sup>13</sup> US	13,373	All subjects at 24-48 hr	97.7%	Through 63 days; buccal miso 800 mcg
Winikoff 2008 <sup>23</sup> US	421	All subjects at 24-36 hr	96.2%	Through 63 days; buccal miso 800 mcg
Winikoff 2012 <sup>19</sup> US	629	All subjects at 24-48 hr	93.5% (Wk 9) 92.8% (Wk 10)	<b>Week 9 v Week 10;</b> buccal miso 800 mcg
Swica 2013 <sup>50</sup> US	301	All subjects at 6-48 hr	96.7 %- home mife 95.6%- clinic mife	Through 63 days; 800 mcg miso
<b>Foreign Studies</b>				
Louie 2014 <sup>14</sup> Azerbaijan	863	794 (92%) at home at 24-48 hr	97%	Through 63 days; buccal miso 800 mcg
Pena 2014 <sup>44</sup> Mexico	1,000	All subjects at 24-48 hr	97.3%	Through 63 days; buccal miso 800 mcg
Bracken 2014 <sup>49</sup> 4 countries	703 (382 v 321)	543 (77%) took miso at 24-48 hr	94.8% (Wk 9) v 91.9% (Wk 10)	<b>Week* 9 v Week 10</b> 400 mcg sublingual miso used
Boersma 2011 <sup>22</sup> Curacao	307	All subjects at 24-36 hr	97.7%	Through <b>70 days (Wk 10); GP care</b> ; buccal miso 800 mcg;
Chong 2012 <sup>40</sup> 400 v 800 buccal	1115 (559 v 563 were enrolled)	851 (76%) at 36-48 hr	96.8% with <u>home</u> miso; 95.1% with clinic miso	Through 63 days; *DB, RCT in Vietnam and Georgia
Goldstone 2012 <sup>20</sup> Australia:	11,155	All subjects at 24-48 hr	96.5%	Through 63 days; <b>buccal miso 800 mcg</b>
Sanhueza 2015 <sup>48</sup>	896	All subjects at 24-48 hr	93.3	Through <b>70 days (Wk 10)</b>
<b>TOTAL</b>	<b>30,763</b>	<b>30,210 (98.2%)</b>	<b>92%-97.7%</b>	<b>Different gestations, and regimens</b>

\*DB, RCT: double-blind, randomized clinical trial.

Source: FDA clinical reviewer table.

**Reviewer comments:**

The above table with data for home administration of misoprostol for 30,763 women in the US and other countries shows a success rate ranging from 91.9 to

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97.7%. The two largest studies (Gatter and Goldstone) pooled showed 97% success using the new proposed dosing regimen with home use of buccal misoprostol. The lowest success rate above of 91.9% in the Bracken study is still supportive for approval and does not differ significantly from results with misoprostol taken in the clinic/office.

Of note is that 4 of the above studies provided data on home use of misoprostol through 70 days gestation.

Home use of misoprostol has been evaluated as part of the proposed protocol in studies including well over 30,000 patients, as well as in studies of home use of both mifepristone and misoprostol. The Raymond (2013) review<sup>18</sup> of early MAB with mifepristone 200 mg and misoprostol (different doses and routes of administration), analyzed 87 trials with 47,283 treated women up to 63 days gestation. The article concludes: "We found no evidence that allowing women to take the misoprostol at home increased the rate of abortion failure or serious complications." It is also notable that the NAF and ACOG guidances encourage home administration of misoprostol and it has been standard protocol for most PPFA clinics for since 2005.

While we do not have age-specific efficacy data for adolescents who took misoprostol at home, it is evident that many adolescents did take buccal misoprostol at home. In the Goldstone 2012 study, there were eight 14 year olds and 931 women ages 15-19 who took misoprostol at home. In the Gatter 2015 study, there were 24 adolescents age 11-14, 82 age 15, 216 age 16, and 435 age 17 who took misoprostol at home. The overall efficacy in these two large studies was excellent, as previously noted.

**Reviewer's Final Recommendation:**

There is no medical rationale against permitting the woman to be given the misoprostol on the day of the initial clinic/office visit and self-administer it at a convenient time in the next 24-48 hours at home. This would avoid another visit and the time, transportation, loss of work, inconvenience, etc. that such a visit would involve. Furthermore, given the fact that 22-38% of women abort within 3 hours and 50-60% within 5 hours of buccal misoprostol<sup>19</sup>, it is preferable for the woman to be in a convenient, safe place (home or at a support person's location) for the expected uterine cramping and vaginal bleeding to occur. The new proposed regimen of 200 mg oral mifepristone followed in 24-48 hours with 800 mcg buccal misoprostol shows acceptable efficacy when misoprostol is self-administered at home.

**6.1.9 Use of a Repeat Dose of Misoprostol if Needed**

Several studies using buccal misoprostol allowed the option of repeat misoprostol at follow-up one week after mifepristone for persistent gestational sac; however, only a few

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studies report specific outcomes. The Chen and Creinin 2015 review<sup>12</sup> of mifepristone with buccal misoprostol for MAB reported on four studies. Chong (2012)<sup>40</sup> provided additional information from 1,122 women. In the study protocols, women with an ongoing pregnancy at follow-up were recommended to undergo uterine suction curettage, whereas women who had retained products of conception were given the options of expectant management, suction curettage/aspiration, or a second dose of misoprostol. Limited additional data were provided by Gatter (2015)<sup>13</sup>: data on the use of a repeat dose of misoprostol were available from a subset of 7,335 women, of whom 87 (1.2%) received a repeat dose. Efficacy results, however, are not stated in the Gatter article, so this study is not included in Table 9, which highlights success rates after a repeat dose of misoprostol in seven published articles that included this specific outcome.

**Table 9: Success with a Repeat Dose of Misoprostol - Incomplete MAB**

Study/Country	Total N	Mife-Miso Interval (hrs)	Took 2 <sup>nd</sup> Dose	Success with 2 <sup>nd</sup> dose N (%)	Comment
*Raghavan 2010 <sup>51</sup> Moldova	277	24	2	2 (100)	Buccal Miso 400
*Winikoff 2008 <sup>23</sup> US	421	24-36	14	13 (93)	Buccal Miso 800
*Winikoff 2012 <sup>19</sup> US	629	24-48	Y <sup>20</sup>	Y <sup>Wk 9- 11 (91) Wk 10: 9 (67)</sup>	Week 9 v. Week 10: Buccal Miso 800
*Louie 2014 <sup>14</sup> Azerbaijan	863	24-48	16	16 (100)	Buccal Miso 800
Chong 2012 <sup>40</sup> Georgia, Vietnam	1122	36-48	47	43 (92)	Buccal Miso 400 and 800 mcg
Boersma 2011 <sup>22</sup> Curacao	307	24-36 hr	5	4 (80)	GP care; Buccal Miso 800 at home
Bracken 2014 <sup>49</sup> 4 countries	703	24-48 hr	33	29 (88)	Sublingual Miso 400
<b>TOTALS</b>	<b>4,018</b>	--	<b>137 (3.4%)</b>	<b>123 (90%)</b>	

\*These 4 studies are in Table 4 of the Chen and Creinin 2015 review article.

Y These data are directly from the Winikoff article; the Chen and Creinin review had incorrect data.

Source: table modified by FDA reviewer from Chen and Creinin 2015 article and 3 other studies.

<sup>51</sup> Raghavan S, et al. Comparison of 400 mcg buccal and 400 mcg sublingual misoprostol after mifepristone medical abortion through 63 days' LMP: a randomized controlled trial. Contraception 2010; 82:513-9.

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**Reviewer's comment:**

The completion success rates shown above are high. While only 3.4% of the women took a second misoprostol dose, 90% of these women avoided a surgical procedure to complete their termination. We believe the option of a repeat dose of misoprostol is acceptable and safe in the case that complete expulsion has not occurred after initial dosing (provided that the pregnancy is not still ongoing): it offers a choice for the healthcare provider and the patient on how to manage an incomplete expulsion (retained products of conception) following the initial treatment. As noted above, the other options are expectant management, suction aspiration in the office, or a surgical D&C in the operating room. It is also of note that it is standard protocol in many US clinics to offer the choice of a repeat misoprostol dose, especially for women with an incomplete termination (retained tissue/clots or a documented non-viable pregnancy). A second dose of misoprostol is generally not offered in the case of a documented ongoing pregnancy following use of mifepristone and misoprostol.

**Reviewer's Final Recommendation:**

Use of a repeat dose of misoprostol may be offered when using the new dosing regimen if the pregnancy has ended, but the expulsion is incomplete.

**6.1.10 Physician v Other Healthcare Provider Treatment**

The Applicant provided data on the efficacy of medical abortion provided by non-physician healthcare providers, including four studies with 3,200 women in randomized controlled clinical trials and 596 women in prospective cohorts. These studies took place in varying settings (urban, rural, international, low resource). The efficacy results are as follows:

- Olavarietta<sup>85</sup> demonstrated efficacy of 97.9% when the MAB was provided by nurses as compared with 98.4% with physicians
- Kopp Kallner<sup>84</sup> showed efficacy of 99% with certified nurse midwives versus 97.4% with physicians
- Warriner<sup>52</sup> demonstrated efficacy of 97.4% with nurses versus 96.3% with physicians
- Puri<sup>83</sup> showed efficacy of 96.8% compared with 97.4% in the “standard care” group

**Reviewer comment:**

**The above findings for MAB efficacy from 5 studies clearly demonstrates that efficacy is the same with non-physician providers compared to physicians or the**

<sup>52</sup> Warriner IK, Wang D, Huong NTM, Thapa K, Tamang A, Shah I et al. Can midlevel health-care providers administer early medical abortion as safely and effectively as doctors? A randomized controlled equivalence trial in Nepal. Lancet 2011; 377: 1155-61.

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**“standard care” treatment.****6.1.11 Follow-up Timing and Method**

Concerning follow-up timing and method, follow-up within the 7-14 day interval after mifepristone administration is universally recommended; however, follow-up does not necessarily need to be done as currently labeled “in the clinic or healthcare provider’s office 14 days after Mifeprex administration.”

One strong argument for flexibility in follow-up timing, location and method after the administration of Mifeprex and misoprostol is to avoid placing an undue burden on either the provider or the patient, while maintaining the ability to identify incomplete terminations. The currently approved labeling specifies three visits (two for dosing, one for follow-up) at fairly rigid times that are often not practical, convenient or necessary.

Several articles were submitted by the Applicant to support flexible follow-up. The most noteworthy article is the 2013 Raymond review<sup>18</sup> of over 45,000 MABs using 200 mg oral mifepristone that concluded: “we observed no significant association between abortion failure rates and the timing of the follow-up evaluation.” This topic is discussed thoroughly in the Section Submission-Specific Primary Safety Concerns.

**Reviewer comment:**

**Follow-up during the 7-14 day window after the administration of mifepristone is necessary to determine that the termination was successful and the woman is in good health. If for some reason the follow-up contact is not made (the woman is “lost to follow-up”), the clinical guidelines of NAF state that “all attempts to contact the patient (phone calls and letters) must be documented in the patient’s medical record.” This guideline emphasizes the importance of follow-up but accepts the fact that women are sometimes lost to follow-up and there is no mechanism that can guarantee 100% follow-up in the normal clinical setting.**

**Reviewer’s Final Recommendation:**

**Follow-up after taking Mifeprex and misoprostol is necessary. The exact timing and method should be flexible and determined jointly by the healthcare provider and the individual woman being treated, and should follow the standard guidelines for the office/clinic where the Mifeprex is being dispensed.**

**Fortunately, there are several choices/methods of follow-up that can be used and it appears that no single option is superior to the others. The woman should always have the option to be seen at the office/clinic.**

**6.1.12 Subpopulations****Parity**

The Raymond (2013) review article<sup>18</sup> had 74 trials with parity data for ~ 32,000 women. In 34 trials whose study populations comprised > 50% nulliparous women, the MAB success rate was 96.4%; in 40 trials with ≤ 50% nulliparous women, the success rate was 94.9%. This suggests that women who have not had a previous term pregnancy

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delivery have a slightly higher early MAB success rate. These data are not definitive, however, because such factors as the dosing regimen, route of administration, and gestational age could also influence the success rates.

**Previous abortion**

One study<sup>26</sup> found that success rates are slightly better in women who have not had a previous abortion. Prior abortion, however, did not appear to be an important risk factor for abortion failure or success (Raymond<sup>18</sup>).

**Race**

There does not appear to be any efficacy difference based on race. Results are reported in studies enrolling a large number of women. Gatter (2015)<sup>13</sup> had five racial/ethnicity groups among over 13,000 women at the PPFA centers in the Los Angeles area; the success rates ranged from a low of 97.2% (African-American) to a high of 97.8% (White, Asian and Other), which is not clinically or statistically significant.

**Adolescents v. Older Women**

There are at least three articles that support the efficacy of MAB in adolescents; each study used the same definition of success as the need for no further medical or surgical intervention:

- Phelps et al. 2001<sup>53</sup> conducted a pilot study in 28 adolescents aged 14-17, at  $\leq$  56 days gestation, using Mifeprex 200 mg followed 48 hours later by misoprostol 800 mcg vaginally. All 28 had complete medical terminations without complications or surgical intervention. Five adolescents did not require any misoprostol.
- Niinimaki et al. April 2011:<sup>54</sup> Finnish Registry from 2000-06 comparing rates of AEs in adolescents and adult women with MAB at  $\leq$  20 weeks gestation, which included 3,024 women  $<$  age 18 and 24,006 women age 18 or older. By gestational age, 2,424 adolescents were  $<$  64 days gestation and 139 were within 64-84 days gestation. The specific dose regimens are not stated and may have varied according to the gestational ages. The odds ratio for an incomplete abortion for adolescents under age 18 compared to the women  $\geq$  age 18 was 0.69, meaning that the younger women had a lower rate of incomplete abortions.
- Gatter, Cleland and Nucatola (2015):<sup>13</sup> US data using the proposed regimen of mifepristone 200 mg and misoprostol 800 mcg buccally through 63 days included 283 women aged 17 years and 322 under age 17 (see Table 10). The 605 women under age 18 had a 98.7% success rate while the 6,674 18-24 year olds had a 98.1% success rate. The four older age groups had success rates that ranged from 96.5 to 97.5% without any need for a surgical procedure and additional treatment. In

<sup>53</sup> Phelps RH, et al. Mifepristone abortion in minors. Contraception 2001;64:339-343.

<sup>54</sup> Niinimaki M, et al. Comparison of rates of adverse events in adolescent and adult women undergoing medical abortion: population register based study. BJM 2011;342: d2111.

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the pediatric population, there were no cases requiring transfusion, hospitalization or treatment for severe infection.

The table below shows the age distribution from the Gatter study. There were 24 adolescents between ages 11-14, 82 adolescents age 15, and 216 age 16 totaling 322 adolescents. As noted, 283 adolescents were age 17.

**Table 10: MAB Success by Age Group**

Age Group (years)	Total N Success (%)	Comment
< 18	605 (98.7)	322 were age 11-16 283 were age 17
18-24	6684 (98.1)	The age distribution here is representative of other US data on MAB - largest group is age 18-24 followed by age 25-29
25-29	3317 (97.5)	
30-34	1613 (96.5)	
35-39	855 (97.0)	
40+	299 (97.3)	
<b>TOTAL</b>	<b>13,373</b> <b>97.7% overall success</b>	

Source: Data from Gatter 2015 review.

**Reviewer comments:**

Data from 3,657 adolescents under age 18 in the above three studies shows a MAB success rate that is consistently equal to or higher than that found in the women older than age 17. It is interesting that five (18%) of the adolescents in the Phelps study did not even need misoprostol. The percentage of women not needing any misoprostol is generally much lower, perhaps 1-3%, in other early MAB studies. From the articles reviewed, efficacy of early MAB in the adolescent population is not a concern.

Additional adolescent data were reported in the Goldstone 2012 study<sup>20</sup>, where there were eight 14 year olds and 931 women ages 15-19 who took misoprostol at home for a MAB up to 63 days gestation. Efficacy and safety data by age groups were not reported in the article.

### **6.1.13 Analysis of Clinical Information Relevant to Dosing Recommendations**

As noted in some of the reviewer comments and tables, there is evidence that lower doses of misoprostol (400 mcg), other ROAs (vaginal and sublingual), inclusion of more advanced gestational ages, and different dosing intervals between mifepristone and misoprostol have shown acceptable efficacy and safety results. However, for the purposes of this NDA review, our final recommendations are focused on the dosing regimen and other requests specifically made by the Applicant.

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**6.1.14 Discussion of Persistence of Efficacy and/or Tolerance Effects**

There is no evidence that repeated medical or surgical abortion is unsafe or that there is a tolerance effect. Return to fertility is well-documented: in the Patient Counseling Information section, the labeling states “inform the patient that another pregnancy can occur following medical abortion and before resumption of normal menses” and “inform the patient that contraception can be initiated as soon as pregnancy expulsion has been confirmed, or before she resumes sexual intercourse.”

**6.1.15 Additional Efficacy Issues/Analyses**

The Applicant has requested that revised labeling provide only for the new proposed regimen and that the original approved regimen be deleted.

**Reviewer Final Recommendation:**

**While there are no safety or efficacy reasons that would lead us to withdraw approval of the currently labeled dosing regimen, we concur that it may be deleted from labeling because very few providers currently use it, and inclusion of two options for dosing could be confusing. Of note, PPFA and NAF guidelines have used mifepristone 200 mg oral and misoprostol 800 mcg (initially given vaginally and now buccally) since 2001.**

**7 Review of Safety****Safety Summary**

- Medical abortion with the new proposed regimen of Mifeprex 200 mg followed 24-48 hours later by misoprostol 800 mcg buccally through 70 days gestation is safe. Major adverse events including death, hospitalization, serious infection, bleeding requiring transfusion and ectopic pregnancy with the proposed regimen are reported rarely in the literature on over 30,000 patients. The rates, when noted, are exceedingly rare, generally far below 0.1% for any individual adverse event. The number of postmarketing deaths associated with Mifeprex pharmacovigilance is very low. Non-vaginal routes of administration of misoprostol have increased and since the *C. sordellii* deaths associated with vaginal misoprostol, there have been no *C. sordellii* deaths. Given that the numbers of these adverse events appear to be stable or decreased over time, it is likely that these serious adverse events will remain acceptably low.
- Common adverse events associated with medical abortion occur at varying but acceptable rates.
- There are scarce cases of uterine rupture associated with early medical abortion. Medical abortion using mifepristone with or without misoprostol in the first trimester is safe from this perspective.

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- There does appear to be an association between angioedema and mifepristone administration. The risks of anaphylaxis and angioedema should be included in the labeling for Mifeprex and there should be continued pharmacovigilance for anaphylaxis.
- Home use of misoprostol has been evaluated as part of the proposed dosing regimen in studies including well over 30,000 patients, demonstrating an acceptable safety profile, with rates of adverse events equal to or lower than those with the approved regimen requiring in-office dispensing of misoprostol. Home use of misoprostol can increase patient convenience, autonomy and privacy without increased burden on the healthcare system.
- In the articles about repeat misoprostol after mifepristone administration, there is little information provided about safety. The need for a second dose is a relatively uncommon occurrence. In studies of medical abortion using misoprostol alone, using two or more doses as compared to one dose of misoprostol does increase the risk of the common adverse event of diarrhea. There are a very few reports of uterine rupture with multiple doses of misoprostol, in almost all cases in women with prior uterine surgery, such as a cesarean section.
- The Applicant demonstrates that alternatives to in-clinic follow-up, including standardized questions, telephone follow-up, and use of low and high sensitivity urine pregnancy tests, serum pregnancy tests, and ultrasound are effective and safe. Loss-to-follow-up rates do not exceed those of in-clinic follow-up. This option can increase flexibility and accessibility of medical abortion for women.
- Medical abortion in adolescents appears to be at least as safe, if not safer, as in adult women. These data support the safety of Mifeprex in adolescents and satisfy requirements for PREA. No information on safety or efficacy if used in premenarchal girls is required, as the medication is not indicated in that subset of the pediatric population.
- Midlevel providers in the United States, such as nurse practitioners, nurse midwives and physician assistants currently provide family planning services and abortion care, including medical abortion care, under the supervision of physicians. In light of the REMS requirements, midlevel providers who are currently practicing abortion care are doing so under the supervision of physicians. Therefore, facilities that employ midlevel providers already have an infrastructure in place for consultation and referral if, as required under the REMS, a prescriber is unable to provide additional care, including surgical management if needed.
- It is appropriate to modify the current adverse event reporting requirements under the REMS, which are currently outlined in the Prescriber's Agreement to include "hospitalization, transfusion or other serious event." FDA has received

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such reports for 15 years, and it has determined that the safety profile of Mifepr is well-characterized, that no new safety concerns have arisen in recent years, and that the known serious risks occur rarely. For this reason, FDA does not believe ongoing reporting of all of the specified adverse events is warranted. The proposed Prescriber's Agreement Form (to replace the Prescriber's Agreement) will continue to require that qualified healthcare providers report any deaths. The Applicant will still be required by law, as is every NDA holder, to report serious, unexpected adverse events as 15-day safety reports, and to submit non-expedited individual case safety reports, and periodic adverse drug experience.

- Upon review of historical documents and of current guidelines for REMS materials, the phrase "under Federal law" can be removed from the Prescribers' Agreement. We concur with (b) (6) review of the REMS document.
- The revised Indication Statement should read:

"Mifepr is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation." Safe use of Mifepr would be enhanced when other information necessary to describe appropriate use (i.e., the need to use Mifepr in a combined regimen with misoprostol and the gestational age for use) is included in the Indication Statement. This would be consistent with current FDA thinking (e.g., the internal Label Review Tool) which states that the indication and use statement should include "Information if drug is to be used only in conjunction with another therapy."

## 7.1 Methods

The assessment of the clinical safety of Mifepr through 70 days gestation is based on the Applicant's submission of numerous articles from the peer-reviewed medical literature. The various studies have different designs, inclusion criteria, dosing regimens and endpoints for safety and efficacy. For the evaluation of safety, this reviewer focused on the studies that evaluated the proposed dosing regimen . All the articles used for this review can be found in the extensive list of references in Section 9.6 at the end of this review.

### 7.1.1 Studies/Clinical Trials Used to Evaluate Safety

The reviewer evaluated safety based on the studies that focused on the proposed dosing regimen, specifically Mifepr 200 mg followed by misoprostol 800 mcg buccally 24-48 hours later, as listed in Table 11 below. Supportive data from studies that have less specific numerical data or studies that included other regimens, specifically with different routes of administration of misoprostol (vaginal, oral, sublingual) are not included in this portion of the review, but are discussed in Sections Major Safety Results and Supportive Safety Results. Table 11 lists the studies referenced in these discussions.

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**Table 11: Studies Used to Evaluate Safety**

Study	
USA	International
Gatter 2015 <sup>13</sup> , retrospective	Ngoc 2014 <sup>16</sup> , Vietnam, prospective
Ireland 2015 <sup>15</sup> , retrospective	Goldstone 2012 <sup>20</sup> , Australia, retrospective
Chong 2015 <sup>17</sup> , prospective single-arm	Boersma 2011 <sup>22</sup> , Curacao, prospective
Winikoff 2012 <sup>19</sup> , prospective	
Grossman 2011 <sup>36</sup> , prospective	
Winikoff 2008 <sup>23</sup> , prospective RCT	
Creinin 2007 <sup>25</sup> , prospective	
Middleton 2005 <sup>24</sup> , prospective	

Source: NDA clinical reviewer table.

**7.1.2 Categorization of Adverse Events**

For the purposes of this review, adverse events categorized as serious include death; hospitalization; infection, including severe infection requiring hospitalization; bleeding requiring transfusion; and ectopic pregnancy. Other non-serious adverse events include: nausea, vomiting, diarrhea, fever, bleeding and cramping.

**7.1.3 Pooling of Data Across Studies/Clinical Trials to Estimate and Compare Incidence**

The data are not pooled across studies as the study designs are quite different. The incidence of individual adverse events is noted for each study, and can be used to provide an estimated range.

**7.2 Adequacy of Safety Assessments****7.2.1 Overall Exposure at Appropriate Doses/Durations and Demographics of Target Populations**

Per the Applicant, there have been approximately 2.5 million US uses of Mifeprex by US women since its approval in 2000. If evaluation is limited to the studies listed in Table 11 focusing specifically on the proposed new dosing regimen, exposure for this safety analysis is based on well over 30,000 patients. The exact number cannot be determined because two retrospective studies (Gatter<sup>13</sup> and Ireland<sup>15</sup>) are likely based on overlapping cohorts of patients from Planned Parenthood clinics in Los Angeles. There are likely some differences in the demographic data for the different studies; therefore, the descriptions are separated into US and international data. However, it is doubtful

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that demographic differences such as race or ethnicity are clinically meaningful in relation to the safety and efficacy of medical abortion. The data do include adolescents exposed to Mifeprex; information on safety in this population is discussed in Section 7.4.5.

**7.2.2 Explorations for Dose Response**

NA for this review.

**7.2.3 Special Animal and/or In Vitro Testing**

NA for this review.

**7.2.4 Routine Clinical Testing**

From this reviewer's assessment of the literature, no routine clinical testing is needed to evaluate the proposed changes to the Mifeprex labeling.

**7.2.5 Metabolic, Clearance, and Interaction Workup**

NA for this review.

**7.2.6 Evaluation for Potential Adverse Events for Similar Drugs in Drug Class**

Please see Important Safety Issues with Consideration to Related Drugs for discussion of potential adverse events for drugs in this class.

**7.3 Major Safety Results****7.3.1 Deaths**

Deaths are rare with medical abortion. Most of the articles provided did not specifically report on deaths with medical abortion. Among the seven US studies, only one reported on deaths (Grossman, 2011<sup>36</sup>) and noted zero deaths among 578 subjects. Among the three international studies, only one<sup>20</sup> reported on deaths. In this retrospective review of 13,345 medical abortions with the proposed regimen, the authors reported only one death, yielding a rate of 0.007%. More information on deaths associated with medical abortion is found in Section 8 Postmarket Experience.

**7.3.2 Nonfatal Serious Adverse Events**

The nonfatal serious adverse events typically discussed in the literature are hospitalization, serious infection, bleeding requiring transfusion and ectopic pregnancy. See narratives below and Table 12, Table 13, and Table 14 for details.

**Hospitalization data:**

Most articles do not report hospitalization data. In the US studies, 19 patients were reported as being hospitalized out of a total of 16,696 subjects. The overall rates range

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from 0.003-1.1%. Only three articles separated out hospitalizations by gestational age. In Gatter 2015<sup>13</sup>, there were 3/8495 hospitalizations among women ≤ 49 days, 3/3142 among women at 50-56 days gestation and none among women at 57-63 days. In Winikoff 2012<sup>19</sup>, there were only two hospitalizations, both among women at 57-63 days, and none in the 64-70 days gestation group. In Creinin<sup>25</sup> two of six total hospitalizations were in the 50-56 days group and two in the 57-63 days group. The two remaining hospitalizations in that study were unrelated to study drug and gestational age information was not provided for these two cases. There were none among women at 64-70 days gestation. See Table 12 below.

Among the international studies, only 3 of 15,109 women were hospitalized, with rates from 0.07-0.6%. These rates were not separated out by gestational age. See Table 12.

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**Table 12: Hospitalizations by Gestational Age**

Study	Design	Subjects (N)	Hospitalizations by gestational age [Total N in subgroup, rate (%)]				
			All Gestational Ages (Overall/not specified)	≤ 49 days	50-56 days	57-63 days	64-70 days
<b>USA</b>							
<b>Gatter 2015<sup>13</sup></b>	retrospective	13,373	6‡ (0.04%)	N=8945 3/8945 (0.03%)	N=3142 (0.1%)	N=1286 0	N/A
<b>Chong 2015<sup>17</sup></b>	prospective	400	2 (0.5%)	NR*	NR	NR	N/A
<b>Winikoff 2012<sup>19</sup></b>	prospective	729	2 (0.27%)	N/A	N/A	N=325 2 (0.61%)^	N=304 0%
<b>Grossman 2011<sup>36</sup></b>	prospective	578	0	N=283 0%	N=103 0%	N=63 0%	N/A
<b>Winikoff 2008<sup>23</sup></b>	prospective	421	3(0.71%)	N=213 NR	N=93 NR	N= 115 NR	N/A
<b>Creinin 2007<sup>25</sup></b>	prospective	546	6 (1.1%)§	N=229 0%	N=172 2 (1.16%)§	N=145 2 (1.38%)§	N/A
<b>Middleton 2005<sup>24</sup></b>	prospective	223	NR	NR	NR	N/A	N/A
<b>International</b>							
<b>Ngoc 2014<sup>16</sup> Vietnam</b>	prospective	1433	1 (0.07%)	NR	NR	NR	N/A
<b>Goldstone 2012<sup>20</sup> Australia</b>	retrospective	13,345	NR	N=11,855 NR	N= 1441 NR	N=49 NR	N/A
<b>Boersma 2011<sup>22</sup> Curacao</b>	prospective	331	2/331 (0.6%)	N=199 NR	N=105 (50-63 d) NR	NR	N=26 NR

\* NR= not reported

‡numbers of hospitalizations for Gatter study includes those for bleeding and infection in subsequent tables.

^ includes woman with sepsis noted in Table 13, and one woman with chronic pancreatitis, recurrent.

§includes subjects receiving transfusions noted in Table 14.

**Source: NDA clinical reviewer table.****Serious infection:**

Infections requiring hospitalization or IV antibiotics were rare in the studies. Only three US studies captured this information, with rates ranging from 0-0.015%. Two studies separated this information out by gestational age. In Gatter 2015<sup>13</sup>, the two serious infections were in women ≤ 49 days gestation. There were no serious infections in

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women at 50-56 or 57-63 days gestation. In Winikoff 2012<sup>19</sup>, there was one serious infection in a woman at 57-63 days and none in women at 64-70 days. See Table 13.

Among the international studies, there were five women hospitalized with rates from 0.03-0.07%. This information was not broken down by gestational age. See Table 13.

**Table 13: Serious Infection by Gestational Age**

Study	Design	Subjects (N)	Serious Infection by gestational age {Total N in subgroup, rate (%)}]				
			All Gestational Ages (Overall/ not specified)	≤ 49 days	50-56 days	57-63 days	64-70 days
<b>USA</b>							
<b>Gatter 2015<sup>13</sup></b>	retrospective	13,373	2 (0.015%)	N= 8945 2 (0.022%)	N= 3142 0%	N=1286 0%	N/A
<b>Chong 2015<sup>17</sup></b>	prospective	400	NR*	NR	NR	NR	N/A
<b>Winikoff 2012<sup>19</sup></b>	prospective	729	1 (0.014%)	N/A	N/A	N=325 1 (0.31%)	N=304 0%
<b>Grossman 2011<sup>36</sup></b>	prospective	578	NR	N=283 NR	N=103 NR	N=63 NR	N/A
<b>Winikoff 2008<sup>23</sup></b>	prospective	421	NR	N=213 NR	N=93 NR	N=115 NR	N/A
<b>Creinin 2007<sup>25</sup></b>	prospective	546	0	N=229 0%	N=172 0%	N=145 0%	N/A
<b>Middleton 2005<sup>24</sup></b>	prospective	223	NR	NR	NR	N/A	N/A
<b>International</b>							
<b>Ngoc 2014<sup>16</sup> Vietnam</b>	prospective	1433	1 (0.07%)	NR	NR	NR	N/A
<b>Goldstone 2012<sup>20</sup> Australia</b>	retrospective	13,345	4 (0.03%)	N=11,855 NR	N=1441 NR	N=49 NR	N/A
<b>Boersma 2011<sup>22</sup> Curacao</b>	prospective	331	NR	N=199 NR	N=105 (50-63 d) NR	NR	N=26 NR

\* NR= not reported

Source: NDA clinical reviewer table.

#### Transfusion data:

With regard to bleeding requiring transfusion, five of the seven US studies included this information as shown in Table 14. The rates of transfusion range from 0.03-0.7%.

Three of the studies provided a breakdown by gestational age. In Gatter 2015<sup>13</sup>, there were the following: one woman in the ≤ 49 days group, three in the 50-56 days and zero in the 57-63 days group. In Winikoff 2012<sup>19</sup>, there were: two in the 57-63 days group

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and 1 in the 64-70 days group. In Creinin 2007<sup>25</sup>, there were two women transfused each in the 50-56 days and 57-63 days. Only one international study<sup>20</sup> (Goldstone 2012) reported on transfusions and 11/13,345 women or 0.08% required transfusion.

**Table 14: Transfusion by Gestational Age**

Study	Design	Subjects (N)	Bleeding Requiring Blood Transfusion by gestational age [Total N in subgroup, rate (%)]				
			All Gestational Ages (Overall/not specified)	≤ 49 days	50-56 days	57-63 days	64-70 days
<b>USA</b>							
<b>Gatter 2015<sup>13</sup></b>	retrospective	13,373	4 (0.03%)	N=8945 1 (0.01%)	N=3142 3 (0.1%)	N=1286 0	N/A
<b>Chong 2015<sup>17</sup></b>	prospective	400	NR	NR	NR	NR	N/A
<b>Winikoff 2012<sup>19</sup></b>	prospective	729	3 (0.41%)	N/A	N/A	N=325 2 (0.53%)	N=304 1 (0.29%)
<b>Grossman 2011<sup>36</sup></b>	prospective	578	1 (0.17%)	N=283 NR	N=103 NR	N=63 NR	N/A
<b>Winikoff 2008<sup>23</sup></b>	prospective	421	NR	N=213 NR	N=93 NR	N=115 NR	N/A
<b>Creinin 2007<sup>25</sup></b>	prospective	546	4(0.7%)	N=229 0	N=172 2 (0.36%)	N=145 2 (0.36%)	N/A
<b>Middleton 2005<sup>24</sup></b>	prospective	223	1 (0.45%)	NR	NR	N/A	N/A
<b>International</b>							
<b>Ngoc 2014<sup>16</sup> Vietnam</b>	prospective	1433	NR	NR	NR	NR	N/A
<b>Goldstone 2012<sup>20</sup> Australia</b>	retrospective	13,345	11 (0.08%)	N=11,855 NR	N=1441 NR	N=49 NR	N/A
<b>Boersma 2011<sup>22</sup> Curacao</b>	prospective	331	NR	N=199 NR	N=105 (50-63 d) NR	NR	N=26 NR

\*NR= not reported

Source: NDA clinical reviewer table.

Ectopic pregnancy:

Ectopic pregnancies were rarely reported in the supporting literature submitted with this efficacy supplement. Only one ectopic pregnancy was reported among 847 patients (0.12%) in Winikoff 2008<sup>23</sup>.

Several studies also included less detailed, though still useful, information on adverse events. Ireland et al<sup>15</sup> conducted a retrospective review of 30,146 women undergoing

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medical or surgical abortion at  $\leq$  63 days gestation at Planned Parenthood clinics in Los Angeles between November 1, 2010 and August 31, 2013. The authors reported that 29 women of 13,221 (0.1%) undergoing medical abortion experienced a major complication, which was defined as including: emergency department presentation, hospitalization, infection, perforation and hemorrhage requiring transfusion. The article did not specify the rate of each event. No deaths or ectopic pregnancies were reported in this study. In 2011, Grossman<sup>36</sup> reported on a study of medical abortion provided through telemedicine, in which 578 women seeking abortion services at Planned Parenthood of the Heartland clinics in Iowa were offered in-person services or telemedicine services. The serious adverse event outcomes are reported in Table 12, Table 13 and Table 14 above, but in addition, he reported on adverse events among all medical abortion patients from July 1, 2008 through October 31, 2009 (a wider time frame than the study itself). Four of 1,172 telemedicine patients (0.3%) required a blood transfusion compared to 0.1% of 2,384 in-person patients. These figures were reported in the paper to support study findings of low rates of serious adverse events, including transfusion. Pena (2014)<sup>44</sup> reported on 1,000 women in Mexico who had a medical abortion up to 63 days gestation. Their paper reported that "there were no serious complications as defined by any occurrence that was unexpected, serious, and related to the induced abortion." Upadhyay et al<sup>55</sup> used 2009 through 2010 patient-level billing data from Medi-Cal, California's state Medicaid program, to evaluate the incidence of complications after abortion, including medical abortion. Major complications were defined as those which required hospitalization, surgery or blood transfusion. There were 11,319 medical abortions, with 35 women (0.31%) having a major complication.

Winikoff (2012)<sup>19</sup> provides data on other serious adverse events through 70 days. Regarding hospitalization, there were zero hospitalizations among 350 women receiving medical abortion at 64-70 days compared with 2/379 women at 57-63 days (0.5% rate). There were no serious infections in the 64-70 day group, compared with 1/379 (0.3% rate) in the 57-63 day group. There was one transfusion (1/350=0.3% rate) in the 64-70 day group, compared with 2/379 (0.5% rate) in the 57-63 day group.

**Reviewer comments:**

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**. Serious adverse events including death, hospitalization, serious infection, bleeding requiring transfusion and ectopic pregnancy with the proposed regimen are rarely reported in the literature. The rates, when noted are exceedingly rare, with rates generally far below 1.0% for any individual adverse event. This indicates that medical abortion with the proposed regimen up through 63 days is safe.**

<sup>55</sup> Upadhyay UD, Desai S, Lidar V, Waits TA, Grossman D, Anderson P, Taylor D. Incidence of emergency department visits and complications after abortion. *Obstet Gynecol* 2015;125(1):175-183.

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**Serious fatal or nonfatal adverse events in the 64-70 days gestation group, were evaluated in one US study (Winikoff 2012)<sup>19</sup>. This study with 379 women in the 64-70 day range is reassuring in that the rates of hospitalization, serious infection and transfusion are no higher than in the lower gestational age ranges. Based on the available safety data on medical abortion in totality, it appears that serious fatal or nonfatal adverse events are very rare through 70 days as well. This regimen should be approved for use through 70 days gestation.**

**Reviewer's Final Recommendation:**

**The regimen of mifepristone 200 mg followed by misoprostol 800 mcg buccally in 24-48 hours is safe to approve for use through 70 days gestation.**

### 7.3.3 Dropouts and/or Discontinuations

The studies included in this safety review revealed a wide range of loss to follow-up, from 0.6% loss to follow-up in the study with telephone follow-up (Ngoc 2014<sup>16</sup>) to 22% in the Grossman<sup>36</sup> study using telemedicine to deliver medical abortion services. One study noted no differences in demographics between the subjects on whom follow-up was available, compared with those on whom no follow-up information was available. Only two studies evaluated other subgroups of women lost to follow-up. Gatter et al 2015<sup>13</sup> found a higher odds of loss to follow-up with age <18 and with income at or below the federal poverty level. Additionally they noted increased odds of loss to follow-up with increasing gestational age. As compared with women 43-49 days gestation, the Odds Ratio (OR) for loss to follow-up at 50-56 days was 1.17 (95% CI 1.05-1.31) and at 57-63 days was 1.28 (95% CI 1.10-1.48). The Boersma study<sup>22</sup> had a 7% loss to follow-up rate. The rate of loss to follow-up was 6.5% at ≤ 49 days, 7.6% at 50-63 days and 7.7% at 64-70 days. No tests for significance were applied to these numbers. Only one study reported on withdrawals: Winikoff 2012<sup>19</sup> reported that 0.27% of patients withdrew and noted this was similar to rates previously reported in the literature.

**Reviewer comment:**

**There is a wide range of loss to follow-up in the studies submitted with the efficacy supplement. The loss to follow-up rate cannot be reliably linked to method of follow-up, though it is notable that the lowest rate of loss-to-follow-up occurred in the Ngoc trial with telephone follow-up (0.6%) and the highest with abortion services provided via telemedicine (22%). The range of loss to follow-up is well-within the range documented in literature covering real-world abortion practice.<sup>1</sup>**

### 7.4 Significant Adverse Events

The label for misoprostol currently includes a boxed warning against the use past 8 weeks gestation, due to the risk of uterine rupture. The (b) (6) safety reviewer and

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(b) (6) conducted separate literature searches on this topic. Chen et al 2008<sup>56</sup> evaluated 488 women with a mean gestational age of 7.8 weeks who received 800 mcg misoprostol as part of a randomized study of misoprostol vs. curettage for early pregnancy failure. They found that 78 (16%) of women in the misoprostol group had previous uterine surgery (>1 C-section or myomectomy). There were no uterine ruptures in that study. Gautam et al<sup>57</sup> reported in 2003 on 66 women up to 60 days' gestation and with previous Caesarean section scar, who received misoprostol 800 mcg for termination and found no uterine ruptures. The literature search also revealed five case reports of uterine rupture.<sup>58, 59, 60, 61, 62</sup> Of these five cases, three occurred with combined mifepristone/misoprostol dosing. Four women had uterine scars, most commonly from at least one prior cesarean section, and one of them had had a prior uterine rupture in labor. Only one woman had no prior uterine scar (Willmott). In these case reports and studies, women received varying doses of misoprostol ranging from 400 mcg to 600 mcg to 800 mcg, and in two, the women received multiple doses of misoprostol (4 and 5 doses in the Wilmot and Bika reports respectively). The women required surgery to repair the uterus or hysterectomy and transfusion. See Table 15.

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<sup>56</sup> Chen BA, Reeves MF, Creinin MD, Gilles JM, Barnhart K, Westhoff C, Zhang J. National Institute of Child Health and Human Development Management of Early Pregnancy Failure Trial. Am J Obstet Gynecol 2008;198(6):626. d1-5 doi: 10.1016/j.ajog.2007.11.045. Epub Feb 15, 2008.

<sup>57</sup> Gautam R, Agrawal V. Early medical termination pregnancy with methotrexate and misoprostol in lower segment cesarean section cases. J Obstet Gynaecol Res 2003; 29(4):251-256.

<sup>58</sup> Khan S, et al. Uterine rupture at 8 weeks' gestation following 600 µg of oral misoprostol for management of delayed miscarriage. J Obstet Gynaecol 2007;27(8):869-870.

<sup>59</sup> Kim JO, et al. Oral misoprostol and uterine rupture in the first trimester of pregnancy: A case report. Reproductive Toxicology 2005;20:575-577.

<sup>60</sup> Jwarah E, Greenhalf JO. Rupture of the uterus after 800 micrograms misoprostol given vaginally for termination of pregnancy. BJOG 2000;107:807.

<sup>61</sup> Bika O, Huned D, Jha S, Selby K. Uterine rupture following termination of pregnancy in a scarred uterus J Obstet Gynaecol 2014;34(2):198-9. doi: 10.3109/01443615.2013.841132.

<sup>62</sup> Willmott F, et al. Rupture of uterus in the first trimester during medical termination of pregnancy for exomphalos using mifepristone/misoprostol. BJOG 2008;115:1575-1577.

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**Table 15: Uterine Rupture with Misoprostol Case Reports**

Study	GA (weeks)	Mifepristone used?	Dose of Misoprostol	Number of doses of misoprostol	Risk Factor for Rupture
<b>Khan</b> <sup>58</sup>	8	Yes; dose not specified	600 mcg	1	1 prior C-section, 1 prior uterine rupture at 32 weeks
<b>Kim</b> <sup>59</sup>	8	No	400 mcg	1	1 prior C-section
<b>Jwarah</b> <sup>60</sup>	8 2/7	No	800 mcg	1	1 prior C-section
<b>Bika</b> <sup>61</sup>	10 2/7	Yes; 200 mg	800 mcg x 2 doses then 400 mcg x 2 doses	4	2 prior C-sections
<b>Willmott</b> <sup>62</sup>	12 3/7	Yes; 200 mg	400 mcg	5	none

Source: NDA clinical reviewer table.

(b) (6) also conducted a review of FAERS cases from January 1, 1965 through October 15, 2015 for reports of uterine rupture with mifepristone alone, misoprostol alone, or a combined regimen, with special interest in cases occurring in women ≤ 10 weeks pregnant (≤ 70 days). The FAERS search retrieved 80 cases of uterine rupture, with 77 citing misoprostol use alone and 3 citing both mifepristone and misoprostol use. No cases of uterine rupture were reported with mifepristone use alone. Vaginal administration of misoprostol was documented in the majority of the cases. The majority of the FAERS cases either occurred in the 3rd trimester of pregnancy, or did not report gestational age. In the cases where the gestational age was not reported, it is likely that most of these cases occurred during the 2nd or 3rd trimester, as many noted the induction of labor as the reason for misoprostol use. The majority of cases also noted at least one additional potential risk factor, with a history of at least one previous c-section, or the use of additional uterotonic drugs (e.g., oxytocin or dinoprostone) being the most commonly reported. The use of misoprostol during the 3rd trimester for the induction of labor, cervical ripening, or both, in women that had at least one previous c-section, was also documented in many cases.

There were only two cases (2.5% of all reports) that reported uterine rupture within the first 10 weeks of pregnancy. In both cases, misoprostol alone was utilized for termination of pregnancy. The first case provided minimal information other than documentation of a 5 week gestation, and an ultrasound noting “an important uterine separation” during an unspecified time after misoprostol (route not specified) administration. The remaining case was also a published case report in which uterine rupture was documented as occurring approximately 2.5 hours after 800 mcg of misoprostol was administered vaginally for cervical preparation prior to surgical termination of pregnancy. The patient was 8 weeks and 2 days pregnant, had a history of a prior c-section, and was of advanced maternal age. (b) (6) concluded that uterine

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rupture associated with the use of mifepristone alone, misoprostol alone, or both, is likely a rare event in the 1st trimester.

**Reviewer comment:**

**Based on the scarcity of reported cases in the first trimester of pregnancy, uterine rupture associated with early medical abortion using mifepristone with or without misoprostol is likely rare. There are a three reports of uterine rupture with mifepristone and misoprostol in the first trimester, most of which occurred in women with prior uterine surgery (e.g., a cesarean section).**

#### **7.4.1 Submission-Specific Primary Safety Concerns**

##### **Summary of requested dosing changes in the NDA Supplement that could affect safety:**

- 1. Proposing a new dosing regimen that uses mifepristone 200 mg oral and the buccal administration of 800 mcg misoprostol at 24-48 hours after Mifeprex and increasing the gestational age from 49 days to 70 days**

The Applicant submitted several articles in support of the proposed dosing regimen as well as increasing the gestational age through 70 days using the proposed regimen, including the 24-48 hour interval. See Section 7.3 Major Safety Results for fatal and nonfatal serious adverse events reported with the proposed regimen and gestational age. The data submitted show these events to be exceedingly rare, indicating that the new dosing regimen and increasing the gestational age to 70 days is safe. Please see Section 7.3 Major Safety Results on Nonfatal Serious Adverse Events for a review of this information.

In further support of changing the dosing interval for misoprostol to 24-48 hours after mifepristone is taken, the Applicant also provided a systematic review by Shaw et al.<sup>63</sup> In this study the authors searched Medline, ClinicalTrials.gov, Popline and the Cochrane Controlled Trials Register and included 20 randomized controlled trials and 9 observational studies. The majority of the studies used the proposed 200 mg dose of mifepristone, but three RCTs and two observational studies used 600 mg of mifepristone. The doses and route of misoprostol administration varied, including doses of 400 mcg, 600 mcg, and 800 mcg, some with repeat doses, and included vaginal, buccal, oral and sublingual routes. There was wide variation in time to administration of the misoprostol, ranging from <24 hours, 24-48 hours, 36-48 hours. Adverse events were not reported consistently. There was no statistically significant difference in nausea, vomiting or diarrhea.

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<sup>63</sup> Shaw KA, Topp NJ, Shaw JG, Blumenthal PB. Mifepristone-misoprostol dosing interval and effect on induction abortion times. *Obstet Gynecol* 2013;121(6):1335-1347.

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**Reviewer comment:**

**Unlike the efficacy data, which is based on studies that look specifically at individual changes proposed by the Applicant, the adverse event data typically come from studies or reviews that include multiple changes (e.g., dose of each drug, dosing interval, gestational age) simultaneously. Therefore, it is not possible to provide safety data specific to each individual change.**

**The changing of the dosing interval to 24-48 hours does not appear to increase the risk of serious fatal or nonfatal adverse events or to increase the risk of common adverse events associated with medical abortion.**

**Reviewer's Final Recommendation:**

**Based on the available evidence, changing the dosing interval between mifepristone and misoprostol to 24-48 hours is safe to approve, including for use in gestations up through 70 days.**

## 2. Home administration of misoprostol

Currently, the Dosage and Administration section of labeling for Mifeprrex requires that patients return to the healthcare provider on Day 3 (two days after ingesting Mifeprrex) for misoprostol. The Applicant proposes that the label be changed to allow for home administration of the misoprostol. The Applicant reasons that all published US trials after the initial trial by Spitz et al<sup>26</sup>, as well as numerous international trials, included distribution of misoprostol for self-administration at home with evidence of safe and effective medical abortion. The Applicant also emphasizes that women usually start having bleeding within two hours of administration of the misoprostol and home administration gives the opportunity for more privacy in the process.

The Applicant submitted many articles to support this change. See Table 8 for US and foreign studies that enrolled over 30,000 women who administered misoprostol at home. None of the studies directly compare home versus clinic/office administration of misoprostol. Most of the studies include protocols where all of the subjects take misoprostol at home. Gatter<sup>13</sup> and Ireland<sup>15</sup> reported separately on large numbers of clients of Planned Parenthood Los Angeles (13,373 and 13,221 clients respectively, though likely with some overlap, in 2010-2011), while Winikoff (2012<sup>19</sup> and 2008<sup>23</sup>), Grossman<sup>36</sup>, Creinin<sup>25</sup> and Middleton<sup>24</sup> reported on smaller numbers of US subjects. Internationally, Goldstone<sup>20</sup> reported on 13,345 medical abortions, while Kopp Kallner<sup>64</sup>, Løkeland<sup>65</sup>, Chong (2012)<sup>40</sup>, Bracken<sup>49</sup>, Pena<sup>44</sup>,

<sup>64</sup> Kopp Kallner H, Fiala C, Stephansson O, Gemzell-Danielsson K. Home self-administration of vaginal misoprostol for medical abortion at 50-63 days compared with gestation of below 50 days. Human Reprod 2010;25(5):1153-1157.

<sup>65</sup> Løkeland M, Iversen OE, Engeland A, Økland I. Medical abortion with mifepristone and home administration of misoprostol up to 63 days' gestation. Acta Obstet Gynecol Scand 2014;93:647-653.

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Ngoc<sup>16</sup>, Louie<sup>14</sup>, Sanhueza Smith<sup>48</sup>, Boersma<sup>22</sup> and Lynd<sup>66</sup> report on smaller numbers of subjects. All of these studies have been reviewed above in Sections Deaths, Nonfatal Serious Adverse Events and Common Adverse Events. This information shows that home administration of misoprostol, as part of the proposed regimen, is associated with exceedingly low rates of serious adverse events, and with rates of common adverse events comparable to those in the original studies of clinic administration of misoprostol.

Swica et al<sup>50</sup> similarly conducted a non-randomized trial with 301 US women, 139 of whom chose home use of mifepristone and misoprostol and 162 of whom chose clinic administration of mifepristone followed by home use of misoprostol. The majority of women (74%) who chose home use took the mifepristone at the appointed 6-48 hour window; for those who took it at a different time than that planned with their provider, the median interval was 25 hours. Over 90% of women in both groups took the misoprostol at the scheduled time, and none waited past 72 hours to take the misoprostol. There were no significant differences in the mean number of days of work or school missed or dependent care needed. Most women made no additional calls (85% for home use group and 90% for office use group) or unscheduled visits to the doctor's office (96% for home use group and 99% for office use group).

The Applicant also submitted a commentary by Gold and Chong<sup>67</sup>, in which they discuss benefits of home administration of Mifeprex and misoprostol. They cite the convenience of scheduling for women, the possibility of greater autonomy and privacy, the lack of burden on staff, and the safety.

**Reviewer comment:**

**Home use of misoprostol has been evaluated as part of the proposed protocol in studies including well over 30,000 patients, as well as in dedicated studies of home use of mifepristone and misoprostol. The studies demonstrate that women take the misoprostol at the recommended time. The safety profile is acceptable, with rates of adverse events equal to or lower than those with the approved regimen requiring in-office dispensing of misoprostol. The studies, including those of home use of mifepristone and misoprostol, show increased convenience, autonomy and privacy for the woman, a smaller impact on their lifestyles, and no increased burden on the healthcare system. The safety data on the home use of misoprostol are adequate to support revision of labeling.**

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<sup>66</sup> Lynd K, Blum J, Ngoc NTN, Shochet T, Blumenthal PD, Winikoff B. Simplified medical abortion using a semi-quantitative pregnancy test for home-based follow-up. Int J Gynecol Obstet 2013;121:144-148.

<sup>67</sup> Gold M, Chong E. If we can do it for misoprostol, why not for mifepristone? The case for taking mifepristone out of the office in medical abortion. Contraception 2015;92:194-196.

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**Reviewer's Final Recommendation:****Based on the available data, home use of misoprostol is safe to approve.****3. Repeat dose of misoprostol if needed.**

The Applicant reasoned that studies include an option for a repeat dose of misoprostol to allow women to avoid a surgical procedure if possible and that this is a safe way to treat an incomplete medical abortion. The Applicant submitted two articles on the repeat use of misoprostol, one randomized trial and one systematic review, that were relevant to this safety review (other articles<sup>12, 17, 22</sup> did not present safety data stratified by number of misoprostol doses). Only one randomized trial reviewed the safety of repeat misoprostol. Coyaji et al<sup>68</sup> conducted a randomized controlled trial of 300 women seeking medical abortion in India. After taking mifepristone, women in one group took 400 mcg misoprostol followed by placebo 3 hours later, while women in the other group took two doses of 400 mcg misoprostol 3 hours apart. As discussed in the efficacy portion of this review, there was no significant difference in the complete abortion rate between the groups; however, the repeat misoprostol reduced need for surgical intervention. Before discharge home, there was no significant difference in the adverse effects observed—similar percentages of women experienced cramping (87% in the single dose group, 89% in the repeat dose group), nausea (both groups 1%), vomiting (both groups 0%), and diarrhea (0% in the single dose group versus 2% in the repeat dose group). More women in the repeat dose arm experienced moderate to severe cramping than women in the single dose arm on Day 4 (24% versus 15%, p=0.032) and on Day 7 (10% versus 4%, p=0.006).

Gallo<sup>69</sup> performed a systematic review of data relating to the safety and efficacy of more than one dose of misoprostol after mifepristone for medical abortion. The search yielded three randomized controlled trials that studied medical abortion ≤ 63 days. The studies included doses of mifepristone ranging from 200 mg to 600 mg followed by misoprostol 6 to 48 hours later, in doses ranging from 400 mcg to 800 mcg via the oral, sublingual or vaginal routes. In two trials, all subjects received repeat misoprostol—in one, three hours later, while in the other study subjects received misoprostol twice a day for days 4-10. In the third trial, subjects only received repeat misoprostol if there was still a gestational sac present. The only side effects discussed in the trials were diarrhea, which was more common in those groups receiving misoprostol orally than in those receiving it exclusively vaginally (26-27% versus 9%). Rash was reported <1%.

There is a good deal of literature on the use of misoprostol alone for medical abortion and in those regimens, doses of up to 800 mcg repeated in three hours have been

<sup>68</sup> Coyaji K, Krishna U, Ambardekar S, Bracken H, Raote V, Mandlekar A, Winikoff B. Are two doses of misoprostol after mifepristone for early abortion better than one? BJOG 2007;114:271-278.

<sup>69</sup> Gallo MF, Cahill S, Castelman L, Mitchell EMH. A systematic review of more than one dose of misoprostol after mifepristone for abortion up to 10 weeks gestation. Contraception 2006;74:36-41.

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used. In a study by Blum et al<sup>70</sup>, misoprostol only, given as two doses of 800 mcg three hours apart, was compared to mifepristone-misoprostol medical abortion where only one dose of 800 mcg misoprostol was administered. The two groups had similar rates of nausea, vomiting, fever and chills. Subjects in the repeat misoprostol group had more diarrhea than in the mifepristone-misoprostol group (83.9% vs. 61.2%, p<0.001). Please see Section 7.4 Significant Adverse Events for additional discussion on safety concerns with repeat doses of misoprostol.

**Reviewer comment:**

**There are few articles concerning the safety of repeat misoprostol after mifepristone administration. Generally, the success of mifepristone-misoprostol medical abortion renders the need for a second dose of misoprostol to be relatively uncommon. In studies of misoprostol alone given using a single repeat dose, there is an increased risk of the common adverse event of diarrhea. There have been rare reports of uterine rupture in women with a prior uterine scar who receive repeated doses of misoprostol.**

**Reviewer's Final Recommendation:**

**Based on the available data, the option for repeat misoprostol in women whose pregnancy has been terminated, but who have not completely expelled the pregnancy is safe and should be approved. For women whose pregnancy is ongoing at follow-up, surgical intervention is recommended, rather than repeated misoprostol. The rare reports of uterine rupture in women with a prior uterine scar who receive repeated doses of misoprostol is discussed in labeling.**

**4. Follow-up timing and method: follow-up is needed, but not necessarily in the clinic or licensed healthcare provider's office at 14 days after mifepristone administration**

The Dosage and Administration section of the current approved label for Mifeprrex stipulates that patients will return for a follow-up visit approximately 14 days after the administration of Mifeprrex to confirm by clinical examination or ultrasonographic scan that a complete termination of pregnancy has occurred. The Applicant acknowledges that follow-up is important to diagnose and treat complications, and to ensure complete abortion or identify ongoing pregnancies. However, the Applicant proposes to change the labeling to state that the provider should perform an assessment at 1-2 weeks, in order to broaden the timeframe and method used, to give patients and providers more flexibility and reduce loss to follow-up rates. Use of ultrasound, serum and urine pregnancy testing (semi-quantitative, and quantitative) and telephone calls have all been evaluated in the literature as options for follow-up of patients after medical

<sup>70</sup> Blum J, Raghavan S, Dabash R, Ngoc NTN, Chelli H, Hajri S, Conkling K, Winikoff B. comparison of misoprostol-only and combined mifepristone-misoprostol regimens for home-based early medical abortion in Tunisia and Vietnam. Int J Gynecol Obstet 2012;118:166-171.

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abortion. Grossman and Grindlay<sup>71</sup> conducted a systematic review of the literature on alternatives to ultrasound for medical abortion follow-up. They identified eight studies, but found that outcomes of interest (ongoing pregnancy) were rare with medical abortion and not consistently defined across studies. Nonetheless, they found that serum hCG, a low sensitivity urine pregnancy test combined with a standardized assessment with multiple questions about women's symptoms, or standardized telephone follow-up, perhaps followed by high-sensitivity urine pregnancy test, all had sensitivities  $\geq 90\%$  and negative predictive values (NPVs)  $\geq 99\%$  and they resulted in a proportion of "screen positives (or women who had a self-assessment of ongoing pregnancy and had an unscheduled visit)  $\leq 33\%$ ."

This reviewer analyzed relevant studies that were submitted by the Applicant and referenced in the Grossman and Grindlay assessment.<sup>71</sup> Perriera et al<sup>21</sup> conducted a prospective cohort study of 139 US women with  $\leq 63$  days gestation undergoing medical abortion at one center. Up to three attempts were made to phone subjects 7 days after taking mifepristone. The subjects were asked to confirm when they took misoprostol and generally to describe their experience. They were then asked a series of five standardized questions to assess for expulsion, including:

- 1 Did you have cramping and bleeding heavier than a period?
- 2 Did you pass clots or tissue?
- 3 What was the highest number of pads you soaked per hour?
- 4 Do you still feel pregnant now?
- 5 Do you think you passed the pregnancy?

If the clinician or the subject did not think the pregnancy had passed, the subject was asked to return to the center for an ultrasound within 7 days. If there was an ongoing pregnancy, women were offered additional misoprostol or a D&C. If the clinician and subject believed the pregnancy had passed, she was instructed to begin birth control or schedule a visit for injectable, implantable or intrauterine contraception. On Day 30, the subject was to perform a urine pregnancy test. Follow-up was obtained for 97.1% of subjects. Four subjects did not complete follow-up (2.9%)—one was never reached by phone, three were and two of them had positive pregnancy tests while one had an inconclusive test. These three never returned for an in-person visit and outcomes are not available on them. The sensitivity for correctly predicting an expelled pregnancy (completed abortion) was 95.9%, specificity was 50%, positive predictive value 97.5% and negative predictive value 37.5%. This study suggests that clinicians and subjects are almost always correct when they believe a pregnancy has passed. The loss to follow-up rate was not higher than for standard medical abortion follow-up.

Fiala et al<sup>72</sup> compared hCG with ultrasound for verification of completed abortion in 217 women  $\leq 49$  days with intrauterine pregnancy in Scotland. Successful expulsions were

<sup>71</sup> Grossman D, Grindlay K. Alternatives to ultrasound for follow-up after medication abortion: a systematic review. *Contraception* 2011;83:504-510.

<sup>72</sup> Fiala C, Safar P, Bygdeman M, Gemzell-Danielsson K. Verifying the effectiveness of medical abortion;

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consistent with a marked decline in hCG values at follow-up. Using 20% of the initial value as cut-off at follow-up gave a high sensitivity. It allowed correct diagnosis in 98.5% of the patients with successful expulsion. When 20% of the initial hCG value was used as cut-off, a positive predictive value for successful expulsion was 99.5%. If the reduction of the hCG level was less than 80%, the negative predictive value was 50% and further evaluation was warranted. By contrast, the reliability of ultrasound examination in diagnosing successful expulsion was 89.8%.

Lynd et al<sup>66</sup> studied 300 women at ≤ 63 days gestation who underwent medical abortion in Vietnam. Women were given mifepristone and sent home with misoprostol and a semi-quantitative urine pregnancy test, a urine cup, instructions and a questionnaire. They were to take the urine test, record their impression of the results and complete the questionnaire on the morning of an in-person follow-up visit 2 weeks after mifepristone administration. Fifty-four women (18.5%) still felt pregnant at the follow-up visit, but only 11 of the semiquantitative urine tests indicated ongoing pregnancies. All 11 correctly identified ongoing pregnancies, with 100% sensitivity and 89.7% specificity. Ten of the 11 women with an ongoing pregnancy understood in-person follow-up was necessary.

Similarly, Cameron et al<sup>73</sup> reported on 1791 women undergoing medical abortion in Scotland, 1,726 (96%) of whom chose self-assessment with a low-sensitivity urine pregnancy test, instructions on how to interpret it, and signs/symptoms of ongoing pregnancy. The rest of the women chose in-clinic follow-up with an ultrasound or a phone call. Eight women in the self-assessment group had ongoing pregnancies, but only four of them had a positive low-sensitivity pregnancy test at the appointed time—within 4 weeks. Of the four who did not follow up in 4 weeks, two had a positive or invalid pregnancy test within two weeks after the medical abortion and should have presented for care, and two reported their pregnancy test was negative and did not present for care. All had successful termination either with repeat medical dosing or surgical aspiration. Most women presented within four weeks, but two women presented only after two missed menses. The delayed follow-up was not different from that for an in-person visit or an ultrasound.

**Reviewer comments:**

**While the number of articles is not extensive, they include almost 2,400 subjects. The Applicant demonstrates that alternatives to in-clinic follow-up are effective and safe, detecting most of the ongoing pregnancies so that women can get needed treatment. It appears that, using standardized questionnaires or instructions or a telephone call along with a low or high sensitivity pregnancy test, ongoing pregnancies can be detected allowing for further treatment. There is some loss-to-follow-up, but the rates do not appear to exceed those associated**

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ultrasound versus hCG testing. Eur J Obstet Gynecol Reprod Biol 2003;109:190-195.

<sup>73</sup> Cameron ST, Glasier A, Johnstone A, Dewart H, Campbell A. Can women determine the success of early medical termination of pregnancy themselves? Contraception 2015;91:6-11.

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with a planned in-clinic follow-up. Women should be allowed to have an in-person visit if desired, but also allowed the flexibility of other options if desired.

It is important to note that since 2005, Planned Parenthood Federation of America has waived the follow-up visit if it poses undue hardships owing to distances from abortion facilities or other reasons, and women manage their follow-up with serial hCG testing.<sup>74</sup> From the clinical reviewers' perspective, this is safe and acceptable. We further note that the NAF 2015 guidelines (page 23) state the following:

"Success of the medical abortion must be assessed by ultrasonography, hCG testing, or by clinical means in the office or by telephone. If the patient has failed to follow-up as planned, clinic staff must document attempts to reach the patient. All attempts to contact the patient (phone calls and letters) must be documented in the patient's medical record."

The ACOG 2014 Practice Bulletin<sup>1</sup> on management of early MAB states "Follow-up after receiving mifepristone and misoprostol for medical abortion is important, although an in-clinic evaluation is not always necessary." Several options for follow up without an office/clinic visit are discussed and no specific method or algorithm is definitely recommended (i.e., it is left to the discretion of the provider and patient).

**Reviewer's Final Recommendation:**

Based on the available evidence, flexibility in the timing and method of follow-up is safe to approve.

## 7.5 Supportive Safety Results

### 7.5.1 Common Adverse Events

According to the currently approved Mifeprrex label,<sup>75</sup> common adverse events include the following:

- Vaginal bleeding up to 16 days, with 8% of women experiencing bleeding up to 30 days. 4.8% of women in the original US trials and 4.3% in the original French trials required administration of uterotonic agents to control the bleeding. Only 1% of women required intravenous fluids and 1% required curettage. In the original French trials, 5.5% of women had a drop in hemoglobin of more than 2 g/dL.
- Abdominal pain in 96% of US women
- Uterine cramping in 83% of French women
- Nausea in 43-61%, vomiting in 18-26%

<sup>74</sup> Fjerstad M. Figuring out follow-up. Mife Matters. Planned Parenthood Federation of America/Coalition of Abortion Providers 2006;13:2-3.

<sup>75</sup> [http://www.accessdata.fda.gov/drugsatfda\\_docs/label/2000/20687lbl.htm](http://www.accessdata.fda.gov/drugsatfda_docs/label/2000/20687lbl.htm)

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- Diarrhea in 12-20%
- Headache in 2-31%
- Dizziness in 1-12%

A review of the literature submitted in the efficacy supplement, which includes Mifepr in the proposed dose but also includes misoprostol administered buccally, vaginally or orally, reveals the following. Table 16 addresses bleeding that did not require transfusion (which is covered in Table 14: Transfusion by Gestational Age above), but was still significant in terms of requiring another intervention or in terms of a decrease in measured hemoglobin. Most of the studies include subjects up to 63 days' gestation, with the exception of Middleton 2005<sup>24</sup>, which includes subject to 56 days, and Sanhueza Smith 2015<sup>48</sup> and Winikoff 2012<sup>19</sup>, which include subjects through 70 days.

**Table 16: Bleeding and Cramping in Literature**

Study	N	Maximal Gestational Age	Route of misoprostol administration	Adverse Event Rate (%)		
				Bleeding requiring intervention*	Bleeding with drop in hemoglobin > 2g/dL	Cramping/pain
Middleton 2005 <sup>24</sup>	216	56 d	buccal	4.2	NR	NR
Coyaji 2007 <sup>68</sup>					NR	87-89
Løkeland 2014 <sup>65</sup>				4.9	NR	96.6
Kopp Kallner 2010 <sup>64</sup>	395	63 d	vaginal	0.5	NR	NR
Pena 2014 <sup>44</sup>	971	63 d	Buccal	1.7	NR*	NR
Ngoc 2014 <sup>16</sup>	1433	63 d	buccal	0.07	NR	NR
Gatter 2015 <sup>13</sup>	13,373	63 d	buccal	1.8	NR	NR
Ireland 2015 <sup>15</sup>	13,221	63 d.	buccal	1.8	NR	NR
Winikoff 2012 <sup>19</sup>	729	70 d	buccal	1.1	NR	NR
Sanhueza Smith 2015 <sup>48</sup>	960	70 d	buccal	1.7	NR	NR

\*Intervention includes aspiration or uterine evacuation, use of uterotronics, intravenous fluids

\*NR=not reported

Source: NDA clinical reviewer table.

**Reviewer Comments:**

Given that Mifepr and misoprostol are taken to terminate an intrauterine pregnancy, vaginal bleeding and cramping or abdominal pain are an expected

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and necessary part of the process; therefore, these should only be considered adverse events if the amount of bleeding or pain exceeds what would be expected for such a process. The rate of bleeding requiring intervention is low and ranges from 0.5% to 4.2%, with the rates in the largest studies being around 1.8%. Two articles parsed the bleeding requiring intervention by gestational age. In Sanhueza Smith et al.<sup>48</sup> the rate was 1.1% (7/622) among women ≤ 56 days, 4.2% (8/190) in women 57-63 days and 1.4% (2/148) in women 64-70 days. In Gatter 2015<sup>13</sup>, the rate was 0.65-1.43% up to 49 days, 2.04% in women 50-56 days, and 2.49% in women 57-63 days. These differing numbers from the two studies do not reveal a trend toward bleeding requiring intervention with increasing gestational age, specifically even through 70 days.

No articles submitted discussed a drop in hemoglobin of > 2 g/dL, most likely because routine laboratory studies are not obtained in medical abortion unless anemia or a medical illness is reported or suspected. Also not surprisingly, pain and cramping are an expected part of the medical abortion process, so most studies do not comment on the percentage of women who experience this.

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Table 17: Common Adverse Events in Literature

Study	N	Maximal GA (days)	Route of Misoprostol	Adverse Event Rate (%)							
				nausea	vomiting	diarrhea	fever	chills	headache	dizziness	weakness
Middleton 2005 <sup>24</sup>	216	56 d	Buccal	70	37	36	42	NR	44	41	51
Blum 2012 <sup>70</sup>			buccal	45.9	37.8	61.2	28.2	30.6			NR
Coyaji 2007 <sup>68</sup>				1	0-2	NR*	NR	NR			NR
Kopp Kallner 2010 <sup>64</sup>	395	63 d	vaginal	87.1	57.3	6.3	26.3	NR	4.1	3.6	2-3.1
Louie 2014 <sup>14</sup>	860	63 d	buccal	38-53	13-25	1-3	15-23†				NR
Peña 2014 <sup>44</sup>	971	63 d	buccal	NR	NR	7.8	8.9†	†	NR	NR	14.3
Creinin 2007 <sup>25</sup>	544	63 d	vaginal	9.4	5.7	4.8	10.3†	†	6.6	6.8	NR
Chong 2012 <sup>40</sup>	563	63 d	buccal	47	22	NR	33†	†	33	24	42
Winikoff 2012 <sup>19</sup>	618	70 d	buccal	50.8	40.6	17.6	11.2	23.5	NR	NR	NR
Sanhueza Smith 2015 <sup>48</sup>	960	70 d	buccal	27	23	44.6	46†	†	14.3	9.7	21

GA = gestational age; \*NR= not reported. † includes fever and chills, which were grouped together

Source: NDA clinical reviewer table.

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**Reviewer comment:**

The range of reported percentages for each adverse event is wide, with some studies reporting virtually no patients experiencing nausea, vomiting or diarrhea, while others report at least half of subjects suffering these side effects. Only the Winikoff 2012<sup>19</sup> article parses out these side effects by gestational age (57-63 days versus 64-70 days). There is no statistically significant difference in the rates of any side effect between gestational age group except for vomiting, where 35.8% of women 57-63 days had vomiting and 45.7% of women 64-70 days did (p=0.008). It is hard to determine a value that could be used in labeling based on these wide variations, but the adverse events are common, expected and well-known with the medical abortion regimen and the ranges should be reported in labeling.

### **7.5.2 Laboratory Findings**

Mifepristone with misoprostol is a well-established regimen for termination of pregnancy. Few laboratory tests are necessary before use of the regimen. Those that are commonly performed include confirmation of pregnancy (urine or serum pregnancy testing) as well as Rh testing (unless it has been previously documented), such that RhD immunoglobulin can be administered as indicated. Pre-medical abortion assessment of hemoglobin or hematocrit is indicated when anemia is suspected. Routine follow-up laboratory testing is also not indicated unless dictated by the patient's clinical condition, for example, heavy bleeding or signs of infection. Lab results are not typically reported in the literature, except for when studies look at decreases in hemoglobin related to bleeding.

### **7.5.3 Vital Signs**

Vital signs are not typically reported in the literature on medical abortion.

### **7.5.4 Electrocardiograms (ECGs)**

Mifepristone used with a prostaglandin analogue has been approved for medical termination of pregnancy since 1988 in France and subsequently in many countries around the globe. It has been well-established that doing an ECG prior to MAB is not standard procedure. It can be done if individual circumstances warrant its use. Literature does not typically report on ECGs.

### **7.5.5 Special Safety Studies/Clinical Trials**

The pediatric studies are addressed in Section 7.6.3.

### **7.5.6 Immunogenicity**

NA to this review

## **7.6 Other Safety Explorations**

This section is not relevant to this application.

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**7.6.1 Additional Safety Evaluations****7.6.2 Human Carcinogenicity**

The Applicant submitted no new data on human carcinogenicity.

**7.6.3 Human Reproduction and Pregnancy Data**

As noted in the efficacy portion of this review, some women who use Mifeprrex do have ongoing pregnancies. Most of these are treated with an aspiration or a surgical evacuation of the uterus; there is little information on outcomes of ongoing pregnancies not terminated by another method. At the time of approval of the drug, the Applicant agreed to two postmarketing commitments, including one to conduct a surveillance study of the outcomes of ongoing pregnancies. On January 11, 2008, the Applicant was released from this commitment due to the lack of an adequate number of women enrolled. The Applicant explained that the small number was due, in part, to the requirement that the patients consent to participation *[in the surveillance study]* after seeking a pregnancy termination.

A review of all of the articles submitted by the Applicant for outcomes of ongoing pregnancies after mifepristone administration yielded minimal information. There is one article reporting a case of a fetus with sirenomelia, a cleft palate and lip, micrognathia, and hygroma; this infant was born to a woman who had received mifepristone as RU 486 at 18 weeks and was reported to Roussel-Uclaf in France in 1989.<sup>76</sup> A prospective observational study<sup>77</sup> from fifteen French pharmacovigilance centers followed women exposed to mifepristone in the first trimester between 1997 and 2010. The study included pregnant women who sought counseling on mifepristone exposure from a pharmacovigilance center or Paris Teratology Information Service (TIS). A total of 105 pregnancies were exposed to mifepristone in the first trimester; 46 to mifepristone alone, and 59 to mifepristone and misoprostol. The mean gestational age at exposure was 7.9 weeks; 81% were exposed between weeks 5 and 9 of gestation. About 40% of patients received 200 mg of mifepristone while about 50% received 600 mg. Of the patients who received both mifepristone and misoprostol, 48 received repeat misoprostol with four receiving 1200–2000 mcg of misoprostol, a significantly higher dose than recommended. Among all exposed women, there were 94 live births (90.4%), 10 (9.6%) miscarriages (including one with a major malformation of major hydrocephalus associated with adductus thumb and a normal karyotype) and one patient had an elective termination of pregnancy for the subsequent diagnosis of trisomy 21. Eight of the ten miscarriages occurred in the mifepristone-only group; however, after potential confounding factors such as maternal age, gestational age at inclusion,

<sup>76</sup> Pons JC, Papiernik E. Mifepristone teratogenicity. Lancet 1991;338(8778):1332-3.

<sup>77</sup> Bernard N, Elefant E, Carlier P, Tebacher M, Barjhoux CE, Bos-Thompson MA, Amar E, Descotes J, Vial T. Continuation of pregnancy after first-trimester exposure to mifepristone: an observational prospective study. BJOG 2013;120:568–575.

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drug exposure, and mifepristone dose were controlled for by logistic regression, the rate of miscarriage did not differ across mifepristone only versus mifepristone-misoprostol groups ( $p= 0.08$ ). Among the live births, the mean gestational age at delivery was 39.5 weeks and there was no difference in birth weights between groups. The overall rate of major congenital malformations among the 95 examinable cases was 4.2% (95% CI 1.2–10.4%), with two cases among 38 patients exposed to mifepristone alone, and two cases among 57 patients exposed to both mifepristone and misoprostol. Three of the four major congenital malformations occurred with exposure to 600 mg of mifepristone, while one occurred in exposure to 400 mg of mifepristone. The malformations included:

- Claude Bernard–Horner syndrome with stridor
- Hydrocephalus with triventricular dilatation and adductus thumb (miscarriage patient noted above)
- Möbius syndrome
- Retrognathism, slight cleft palate, trismus, swallowing disorder, club foot with four toes, incomplete genital development and mild hypoplasia of the cerebellar vermis

The authors posit that the cases of major malformations in patients exposed to mifepristone alone could be explained by associated medical conditions, for example, the case of congenital Claude Bernard Horner syndrome could have been related to traumatic vaginal delivery of a high birth weight newborn, a well-recognized cause of this syndrome, while the spontaneously aborted hydrocephalic fetus may have been caused by streptococcus B chorioamnionitis, which was subsequently confirmed on pathological examination, or be an X-linked hydrocephalus. The authors also note that the two cases of major malformations in patients exposed to both mifepristone and misoprostol were consistent with malformations described after exposure to misoprostol alone. The authors concluded that major malformations after first-trimester exposure to mifepristone is only slightly higher than the expected 2–3% rate in the general population, which was reassuring regarding the risk evaluation for continuation of pregnancy after mifepristone exposure.

There are reports that misoprostol can result in congenital anomalies when used during the first trimester, including defects in the frontal or temporal bones, limb abnormalities with or without Mobius syndrome.<sup>1</sup> The Korlym label notes in Important Safety Issues with Consideration to Related Drugs: “In a report of thirteen live births after single dose mifepristone exposure, no fetal abnormalities were noted.”

**Reviewer Comment:**

**There are anomalies associated with the use of misoprostol in the first trimester. The risk of teratogenic effects with a continued pregnancy after a failed pregnancy termination with Mifepr in a regimen with misoprostol is unknown. Birth defects have been reported with a continued pregnancy after a failed pregnancy termination with Mifepr in a regimen with misoprostol, but it is not clear if this just represents the usual background rate of birth defects.**

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As discussed above, FDA requested at the time of initial approval that the Applicant conduct a surveillance study of the outcomes of ongoing pregnancies. The Applicant was subsequently released from this commitment because it had been unable to enroll a sufficient number of women with ongoing pregnancies after an attempted medical abortion in the surveillance study.

#### 7.6.4 Pediatrics and Assessment of Effects on Growth

The Applicant submitted no new data on assessment of effects on growth in pediatric patients. The Applicant did submit data on efficacy and safety of medical abortion in adolescents, using the proposed regimen of 200 mg oral Mifeprex followed by 800 mcg buccal misoprostol 24-48 hours later at home, in order to satisfy requirements for PREA. Gatter et al (2015)<sup>13</sup> included data on 322 adolescents. (b) (6), (b) (4)

The adolescent efficacy was similar to that of all older women; this implies that compliance in taking the misoprostol dose properly at home was also acceptable. The study included adolescents aged 11-16 per Table 18 below:

**Table 18: Age of Adolescents Undergoing Medical Abortion**

Age	# Subjects
11	1
12	1
13	2
14	20
15	82
16	216

Source: (b) (6), (b) (4) NDA 20687s20

(b) (4), (b) (6) As is evident in the table, no adolescents had a hospitalization, severe infection or hemorrhage which required a transfusion.

**Table 19: Serious Adverse Events in Adolescents vs. Adults**

	Under 17	17+	All
Transfusion	0.00% (0/251)	0.03% (4/13,122)	0.03% (4/13,373)
Hospitalization	0.00% (0/251)	0.05% (7/13,122)	0.05% (7/13,373)
Infection	0.00% (0/251)	0.02% (2/13,122)	0.01% (2/13,373)

Source: (b) (6), (b) (4) NDA 20687s20

In 2011, Niinimäki et al<sup>54</sup> published a retrospective cohort study of the Finnish abortion registry from 2000-2006, in which they evaluated the rates of adverse events in 3,024

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adolescents and 24,006 adult women undergoing medical abortion (regimen unspecified). The study population included women  $\leq$  20 week's gestation; 84.6% of the adolescents were  $\leq$  12 weeks, while 86.6% of the adults were  $\leq$  12 weeks. Adolescents ranged in age from 13-17, with a mean age of 16.1 years. The study showed that after adjustment for parity, previous abortion, marital status, types of residence, duration of gestation and year of abortion, in adolescents, the adjusted ORs were significantly lower for hemorrhage (0.87, 95% CI 0.77 to 0.99), incomplete abortion (0.69, 95% CI 0.59 to 0.82) and surgical evacuation (0.78, 95% CI 0.67 to 0.90) compared to adults. There was no significant difference in the OR for infection (0.97, 95% CI 0.73 to 1.30).

Phelps<sup>53</sup> had previously conducted a pilot study in 28 adolescents aged 14-17, at  $\leq$  56 days gestation, using Mifeprrex 200 mg followed 48 hours later by misoprostol 800 mcg vaginally. As reported in Section Subpopulations, 100% of study subjects had a complete abortion, with five not requiring misoprostol. There were no serious adverse events. Subjects noted common expected adverse events including bleeding (100%), cramping (95%), nausea (62%), and vomiting (43%).

It is also important to consider adherence to the proposed regimen (including taking misoprostol at a location other than the clinic) and adherence to follow-up among adolescents versus adults.

There are no data specifically comparing adherence to the regimen among adolescents  $<17$  with women  $\geq 17$  years old. The Gatter<sup>13</sup> study clearly demonstrates the efficacy and safety is the same for both age groups, suggesting that there is no clinically significant difference in adherence to the regimen between age groups. The Goldstone<sup>20</sup> article included 8 subjects aged 14 and 931 subjects aged 15-19. The efficacy and safety are not separated out by age; however, all subjects did take the proposed regimen and overall efficacy and safety is reassuring, indicating that adolescents and adults alike likely did adhere to the mifepristone and misoprostol regimen in a safe and effective way.

Regarding adherence to follow-up, four articles included 346 subjects  $<17$  years old. Ngoc<sup>16</sup> is based in Vietnam and Cameron<sup>73</sup> is based in Scotland, while Gatter<sup>13</sup> and Horning<sup>78</sup>, are US-based studies. (b) (4), (b) (6)

. The difference in the follow-up rate for the combined data is 6.5%. The Gatter study accounts for 85% of all patients being compared. The difference in follow-up adherence is not clinically relevant as there is no difference in efficacy between the two age groups.

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**Table 20: Adherence to Follow-Up Among Adolescents vs. Adults**

	<17 years old			≥17 years old		
	N	# Adherent	Adherence %	N	# Adherent	Adherence %
Gatter <sup>13</sup>	322	251	78.0%	15,517	13,122	84.6%
Cameron <sup>71</sup>	5	4	80.0%	607	516	85.0%
Ngoc <sup>16</sup>	1	1	100.0%	1,406	1,345	95.7%
Horning <sup>78</sup>	18	16	88.9%	846	648	76.6%
<b>TOTAL</b>	<b>346</b>	<b>272</b>	<b>78.6%</b>	<b>18,376</b>	<b>15,631</b>	<b>85.1%</b>

**Reviewer Comment:**

Medical abortion in adolescents appears to be at least as safe, if not safer, as in adult women. Adolescents appear able to comply with the regimen, including use of misoprostol outside of the clinic setting, as well as with alternative follow-up methods. These data support the safety of Mifeprax in adolescents and satisfy requirements for PREA. No information on safety and efficacy of use in premenarchal girls is required, as the medication is not indicated in that subset of the pediatric population.

**Reviewer's Final Recommendation:**

The available evidence supports that Mifeprax and the new proposed dosing regimen are safe to use in adolescents.

**7.6.5 Overdose, Drug Abuse Potential, Withdrawal and Rebound**

The Applicant submitted no new data on overdose, drug abuse potential withdrawal and rebound.

**7.7 Additional Submissions / Issues**

Summary of additional changes in labeling that may affect safety of Mifeprax

**1. Change in labeled time for expulsion from 4-24 hours to 2-24 hours**

The Applicant proposes to change the time to expulsion described in the labeling from 4-24 hours to 2-24 hours post misoprostol to more accurately reflect the data and real-life experiences with the drug. The Applicant reasons that in the large US trial upon

<sup>78</sup> Horning EL, Chen BA, Meyn LA, Creinin MD. Comparison of medical abortion follow-up with serum human chorionic gonadotropin testing and in-office assessment. Contraception 2012;85:402-407.

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which labeling is based (Spitz, 1998<sup>26</sup>), the median time to expulsion was 4 hours. Indeed, in that study, women were observed for several hours after misoprostol administration, and during the four hours of observation, 49% of the women expelled the products of conception, and 60% had by the fifth hour. Several studies are provided to corroborate this. Only one uses buccal misoprostol; however, the misoprostol was administered within 5 minutes of the Mifeprex, not at the 24-48 hour interval as proposed in this supplement. Nonetheless, in this trial, Lohr<sup>79</sup> found the median time to onset of cramping to be 2 hours (range 10 minutes to 13 hours) and bleeding to be 3 hours (range 9 minutes to 11 hours). This shorter duration to expulsion is also seen in several other pilot studies submitted where subjects took vaginal misoprostol immediately or within 6-8 hours of mifepristone. If the focus is shifted to the randomized controlled studies that report times to onset of bleeding and cramping and include vaginal misoprostol, we find data confirming the timing of expulsion in the 2-24 hour window proposed by the Applicant. Creinin<sup>25</sup> noted a median time to onset of cramping of 1.7 hours and to onset of bleeding of 2 hours after misoprostol (administered 24 hours after Mifeprex). In a similar study<sup>80</sup> comparing misoprostol administered 24 vs. 6-8 hours after Mifeprex, the median time to onset of cramping was 1.5 hours and to bleeding was 2 hours in women with misoprostol given 24 hours after Mifeprex.

**Reviewer comment:**

**The data from vaginal and buccal administration of misoprostol around 24 hours after mifepristone support the assertion that bleeding and cramping begin before the 4 hour mark that is currently labeled. Therefore the label should be revised to make this clearer. Median times seem to be around 1.5 to 2 hours. It is reasonable to label the time to expulsion 2-24 hours, but it could be labeled as beginning even earlier. A clearer label will help providers better counsel patients and patients can better select an appropriate time frame within the 24-48 hour window to take their misoprostol and can be prepared when the expulsion starts.**

**Reviewer's Final Recommendation:**

**Based on the available evidence, it is acceptable to revise the label so that it notes that the time to expulsion after misoprostol dosing is 2-24 hours.**

**2. Use of the term “**

(b) (4)

The Applicant proposes to use the term “(b) (4) in place of all other terms in labeling and in the REMS materials, for consistency and (b) (4) The Applicant

<sup>79</sup> Lohr PA, Reeves MF, Hayes JL, Harwood B, Creinin MD. Oral mifepristone and buccal misoprostol administered simultaneously for abortion: a pilot study. Contraception 2007;76:215-220.

<sup>80</sup> Creinin MD, Fox MC, Teal S, Chen A, Schaff EA, Meyn LA. MOD Study Trial Group: A randomized comparison of misoprostol 6-8 hours versus 24 hours after mifepristone for abortion. Obstet Gynecol 2004;103:851-859.

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submitted an article demonstrating that nurse practitioners, certified nurse midwives and physician assistants can safely provide aspiration abortion.<sup>81</sup> The Division asked the Applicant to provide articles specifically addressing the provision of medical abortion services by non-physician practitioners, since that is the issue at hand.

The Applicant provided data on the efficacy of medical abortion provided by non-physician healthcare providers, including four studies with 3,200 women in randomized controlled clinical trials and 596 women in prospective cohorts. These studies took place in varying settings (urban, rural, international, low resource). The efficacy results are discussed in Section 6.1.10.

Regarding the safety of medical abortion provided by non-physician health care providers, a systematic review by Renner<sup>82</sup> identified five studies with a total of 8,908 subjects. A RCT in Nepal included 1,104 of those subjects, comparing medical abortions by nurses or auxiliary nurse midwives with those offered by physicians. Outcome data on 1,077 women showed no serious complications (hemorrhage requiring transfusion or condition necessitating hospitalization) and the rate of ongoing pregnancy or incomplete abortion did not vary by physician versus midlevel provider. Also in Nepal, Puri et al<sup>83</sup> described training female community health volunteers to provide education, and training auxiliary nurse midwives to provide medical abortion in intervention districts, and compared knowledge and medical abortion outcomes with those in neighboring districts where there were no interventions. Medical abortions were performed on 307 women in the intervention areas and 289 women in the comparison areas. There were five incomplete abortions (1.6%) in the intervention areas, treated with manual vacuum aspiration by the auxiliary nurse midwives, and 7 (2.4%) incomplete abortions in the comparison areas. The difference was not statistically significant. Kopp Kallner<sup>84</sup> conducted a randomized controlled equivalence trial of 1,068 women in Sweden who were randomized to receive medical abortion care from two nurse midwives experienced in medical terminations and trained in early pregnancy ultrasound versus a group of 34 physicians with varying training and experience. The trial showed fewer complications for the nurse midwife group, though this was not statistically significant (4.1% for nurse midwives, versus 6.1% for doctors, p=0.14).

<sup>81</sup> Weitz TA, Taylor D, Desai S, Upadhyay UD, Waldman J, Battistelli MF, Drey EA. Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver. Am J Public Health 2013;103:454-461.

<sup>82</sup> Renner R-M, Brahmi D, Kapp N. Who can provide effective and safe termination of pregnancy care: a systematic review. BJOG 2013;10:23-31.

<sup>83</sup> Puri M, Tamang A, Shrestha P, Joshi D. The role of auxiliary nurse-midwives and community health volunteers in expanding access to medical abortion in rural Nepal. Reproductive Health Matters 2015;Suppl(44):94-103.

<sup>84</sup> Kopp Kallner H, Gomperts R, Salomonsson E, Johansson M, Marions L, Gemzell-Danielsson K. The efficacy, safety and acceptability of medical termination of pregnancy provided by standard care by doctors or by nurse-midwives: a randomized controlled equivalence trial. BJOG 2015;122:510-517.

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There were no serious complications and no blood transfusions in the study. There was no difference in unscheduled visits. Nurse midwives did call for more second opinions (26%) versus doctors (4%). Olavarrieta<sup>85</sup> conducted a randomized controlled non-inferiority trial in Mexico City abortion clinics. Eight physicians and seven nurses who had not previously independently provided medical abortion care received 1.5 weeks of training. A total of 1,088 women were randomized to two groups of providers. Nurses were not found to be inferior to physicians in the provision of abortion care. There was only one serious adverse event in the physician group, a woman requiring admission and surgical aspiration for heavy bleeding. Nurses requested consultation with an experienced obstetrician in 9 cases, whereas physicians requested consultation only twice.

**Reviewer Comments:**

**The Applicant provided data from over 3,200 women in randomized controlled trials and data on 596 women in prospective cohorts comparing medical abortion care by physicians versus nurses or nurse midwives. The studies were conducted in varying settings (international, urban, rural, low-resource) and found no differences in efficacy, serious adverse events, ongoing pregnancy or incomplete abortion between the groups. Two studies did show that nurses or nurse midwives called for more second opinions than physicians, but these numbers were a small portion of the total subjects included.**

**Midlevel providers in the United States, such as nurse practitioners, nurse midwives and physician assistants currently provide family planning services and abortion care, including medical abortion care, under the supervision of physicians. The data here demonstrate that it would be safe to allow healthcare providers who are licensed to prescribe medications and who meet the criteria in the REMS to become certified to provide medical abortion care with Mifeprex and misoprostol. Midlevel providers are already practicing abortion care under the supervision of physicians, and the approved labeling and the REMS Prescriber's Agreement already stipulate that prescribers must be able to refer patients for additional care, including surgical management if needed. Therefore, facilities that employ midlevel prescribers already have an infrastructure in place for consultation and referral.**

**Reviewer's Final Recommendation:**

**Based on the available evidence, it is safe for midlevel providers to administer medical abortion. The term in the revised Prescriber Agreement Form will be "a healthcare provider who prescribes." Per the review by the (b) (6) dated March 29, 2016, this term provides an accurate**

<sup>85</sup> Olavarrieta CD, Ganatra B, Sorhaindo A, Karver TS, Seuc A, Villalobos A, Garcia SG, Pérez M, Bousiegez M, Sanhueza P. Nurse versus physician-provision of early medical abortion in Mexico: a randomized controlled non-inferiority trial. Bull World Health Organ 2015;93:249-258.

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representation of the varied practitioners who are prescribers, while at the same time using language that is consistent with statute. We concur with the (b) (6) review.

### 3. Removal of references to “Under Federal Law” from the Prescriber’s Agreement

The Applicant requests removal of the phrase “under Federal law” from the Prescriber’s Agreement portion of the REMS materials. The phrase appears in two places:

- “Under Federal law, Mifeprex must be provided by or under the supervision of a licensed physician who meets the following qualifications:
  - Ability to assess the duration of pregnancy accurately.
  - Ability to diagnose ectopic pregnancies.
  - Ability to provide surgical intervention in cases of incomplete abortion or severe bleeding, or have made plans to provide such care through others, and are able to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.”
- “Under Federal law, each patient must be provided with a Medication Guide. You must fully explain the procedure to each patient, provide her with a copy of the Medication Guide and Patient Agreement, give her an opportunity to read and discuss them, obtain her signature on the Patient Agreement, and sign it yourself.”

The Applicant rationalizes that all of the conditions of Mifeprex approval, including the REMS, are under Federal law and that the statement is redundant and are no more subject to Federal law than the other conditions of approval.

**Reviewer comment:**

A rationale for the original inclusion of the phrase “Under Federal law” cannot be discerned from available historical documents, nor is it consistent with REMS materials for other products. All the conditions of approval, including the REMS materials, are under Federal law; therefore, the phrase is unnecessary and can be removed from the Prescriber’s Agreement.

**Reviewer’s Final Recommendation:**

The term “under Federal law” can be removed from the Prescriber’s Agreement.

### 4. Addition of misoprostol to the indication statement

The Indication and Usage section of the currently approved labeling is as follows:

“Mifeprex is indicated for the medical termination of intrauterine pregnancy through 49 days’ pregnancy. For purposes of this treatment, pregnancy is dated from the first day of the last menstrual period in a presumed 28 day cycle with ovulation

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occurring at mid-cycle. The duration of pregnancy may be determined from menstrual history and by clinical examination.

Ultrasonographic scan should be used if the duration of pregnancy is uncertain, or if ectopic pregnancy is suspected.

Any intrauterine device ("IUD") should be removed before treatment with Mifeprex begins.

Patients taking Mifeprex must take 400 mcg of misoprostol two days after taking mifepristone unless a complete abortion has already been confirmed before that time (see DOSAGE AND ADMINISTRATION).

Pregnancy termination by surgery is recommended in cases when Mifeprex and misoprostol fail to cause termination of intrauterine pregnancy (see PRECAUTIONS)."

The Applicant proposed two alternative indication statements, both of which include reference to misoprostol:

Or

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The Applicant provides the rationale that:

- the two drugs are used in combination and placing misoprostol in the indication statement early on in labeling gives it greater prominence and highlights the importance of completing the full treatment regimen

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- the mention of misoprostol enhances the goal of labeling, which is to give healthcare providers information necessary for safe and effective use of Mifeprex.

Subsequently on February 25, 2016, the Applicant proposed (b) (4) (b) (4) gestational age through 70 days, based on the literature already submitted.

**Reviewer comment:**

We recommend that the Indication Statement read:

**“Mifeprex is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation.”**

The rationale for this is that:

- All supporting data are based on the combined regimen
- Inclusion of misoprostol in the Indication Statement would be consistent with the rest of Mifeprex labeling and with current medical practice
- It would be consistent with current FDA thinking (e.g., the internal Label Review Tool) which states that the indication and use statement should include “Information if drug is to be used only in conjunction with another therapy.”

**Reviewer’s Final Recommendation:**

Misoprostol should be included in the Indication Statement for Mifeprex.

## 8 Postmarket Experience

A comprehensive review of the adverse events associated with Mifeprex from September 28, 2000 through November 17, 2015, performed by (b) (6)

(b) (6), yielded the following information on reported deaths. Regarding the US cases, there were 17 reported deaths. Deaths were associated with sepsis in eight of the 17 (seven cases tested positive for *Clostridium sordellii*, one case tested positive for *Clostridium perfringens*). Seven of the eight fatal sepsis cases reported vaginal misoprostol use; one case reported buccal misoprostol use. Seven of the nine remaining U.S. deaths involved two cases of ruptured ectopic pregnancy and one case each of the following: substance abuse/drug overdose; methadone overdose; suspected homicide; suicide; and a case of delayed onset toxic shock-like syndrome. In the eighth case, the cause of death could not be established despite performance of an autopsy; tissue samples were negative for *C. sordellii*. The autopsy report on the ninth death became available to the Agency and was reviewed on December 2, 2015. It showed the woman died of pulmonary emphysema.

There were 11 additional deaths in women in foreign countries who used mifepristone for medical termination of pregnancy. These fatal cases were associated with the

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following: sepsis (*Clostridium sordellii* identified in tissue samples) in a foreign clinical trial; sepsis (Group A *Streptococcus pyogenes*); a ruptured gastric ulcer; severe hemorrhage; severe hemorrhage and possible sepsis; "multivisceral failure;" thrombotic thrombocytopenic purpura leading to intracranial hemorrhage; toxic shock syndrome (*Clostridium sordellii* was identified through uterine biopsy cultures); asthma attack with cardiac arrest; respiratory decompensation with secondary pulmonary infection 30 days after mifepristone in a patient on the lung transplant list with diabetes, a jejunostomy feeding tube, and severe cystic fibrosis; and a case of *Clostridium sordellii* sepsis (from a published literature report).

**Reviewer Comments:**

While an exact rate of death with use of mifepristone cannot be calculated from this information, given that there have been over 2.5 million uses of Mifepristex by US women since its marketing in 2000, the number of deaths is very low.

Moreover, half of the deaths were associated with *C. sordellii* sepsis. Seven out of 8 of these cases occurred in women who used misoprostol via the vaginal route while one used buccal misoprostol. Since at least 2006, PPFA (comprising the majority of US medical abortion providers) switched its national guidelines to avoid vaginal administration of misoprostol (even though the data did not find a causal relationship).<sup>23</sup> Although the possibility that Mifepristex might increase the likelihood of infection by adversely affecting immune system function has been raised, the overall event rate of serious infections does not support this.

Since 2009, there have been no *C. sordellii* deaths associated with medical abortion in the US. This reviewer finds that the postmarketing data on deaths associated with medical abortion demonstrate low numbers and an improved safety profile with the buccal route of misoprostol administration as compared with the vaginal route.

The review by (b) (6) (b) (6) also yielded the following

Table 21 summarizing hospitalizations, blood loss requiring transfusions, and severe infections.

**Table 21: US Postmarketing AEs- Mifepristone for Medical Abortion**

Date ranges of reports received	09/28/00 <sup>†</sup> -10/31/12	11/1/12 - 04/30/14 <sup>‡</sup>
Cases with any adverse event	2740	504
Hospitalized, excluding deaths	768	110
*Experienced blood loss requiring transfusions <sup>§</sup>	416	66
Infections <sup>  </sup> (*Severe infections <sup>¶</sup> )	308 (57)	37 (5)

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† U.S. approval date.

‡ FDA implemented FAERS on September 10, 2012, and migrated all of the data from the previous reporting system (AERS) to FAERS. Differences may exist when comparing case counts in AERS and FAERS. FDA validated and recoded product information as the AERS reports were migrated to FAERS. As a result of this change, it is not recommended to calculate a cumulative number when reviewing the data provided in Table 5.

\* The majority of these women are included in the hospitalized category in Table 5.

§ As stated in the approved Mifeprex (mifepristone) labeling, bleeding or spotting can be expected for an average of 9-16 days, and may last for up to 30 days. Excessive vaginal bleeding usually requires treatment by uterotronics, vasoconstrictor drugs, curettage, administration of saline infusions, and/or blood transfusions.

|| This category includes endometritis (inflammation resulting from an infection involving the lining of the womb), pelvic inflammatory disease (involving the nearby reproductive organs such as the fallopian tubes or ovaries), and pelvic infections with sepsis (a serious systemic infection that has spread beyond the reproductive organs). Not included are women with reported sexually transmitted infections such as chlamydia and gonorrhea, cystitis, and toxic shock syndrome not associated with a pelvic infection.

¶ This subset of infections includes cases that were determined to be severe based on medical review of the available case details. Severe infections generally result in death or hospitalization for at least 2-3 days, require intravenous antibiotics for at least 24 hours and total antibiotic usage for at least 3 days, or have other physical or clinical findings, laboratory data, or surgery that suggest a severe infection.

**Source: Review by** (b) (6) (b) (6) **dated**  
08/27/2015.

The (b) (6) review also describes ectopic pregnancies:

**Table 22: US Postmarketing Ectopic Cases- Mifepristone for Medical Abortion**

Date Range of Cumulative Reports	9/28/2000-10/31/14*	11/1/14-4/30/2015
Ectopic Pregnancies†	79	10

\* U.S. approval date

† Administration of mifepristone and misoprostol is contraindicated in patients with confirmed or suspected ectopic pregnancy (a pregnancy outside the uterus).

**Source:** (b) (6) (b) (6) (b) (6) **Mifepristone U.S. Post-marketing Adverse Events 6 month Update Summary through 04/30/2015, dated 08/20/2015.**

**Reviewer comment:**

**While exact rates cannot be calculated, as these reports are spontaneously generated, a few conclusions can be drawn from the information provided:**

- **Given that there have been over 2.5 million uses of Mifeprex by US women since its marketing in 2000, including the use of the proposed dosing regimen and extended gestational age at many clinic/office sites, the numbers of hospitalizations, severe infections, blood loss requiring transfusion and ectopic pregnancy will likely remain acceptably low.**
- **The numbers of each of these adverse events appears to have remained steady over time, with a possible decrease in severe infections.**

A discussion of a (b) (6) review of uterine rupture is found in the Section Significant Adverse Events.

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(b) (6) identified another safety signal in a review dated January 27, 2016. A FAERS search retrieved one case of anaphylaxis and six cases of angioedema with mifepristone administration. A literature search did not reveal any case reports of either adverse event with mifepristone. Six of the seven cases were seen in women using mifepristone for termination of pregnancy. Six of the seven cases noted some type of medical intervention, such as treatment with an antihistamine, a histamine H<sub>2</sub> antagonist, a corticosteroid, or a combination of the various medications. Hospitalization was noted in three of the seven total cases; all three hospitalization cases occurred in patients who experienced angioedema.

In the case of anaphylaxis, it was reported that the patient experienced an anaphylactic reaction three hours after mifepristone administration; however, co-administration of doxycycline was also documented. Because both mifepristone and doxycycline were discontinued simultaneously, the exact cause of the anaphylactic reaction cannot be determined.

Regarding angioedema, five of the six cases noted a time-to-onset within 24 hours of mifepristone administration for the termination of pregnancy, with no additional suspect medications reported. The remaining case of angioedema with mifepristone reported a time-to-onset of approximately one week in a Cushing's syndrome patient with a complex medical history and multiple concomitant medications; however, this case noted both a positive dechallenge and rechallenge upon sole re-introduction of mifepristone therapy. Evaluation of these FAERS cases provides supportive evidence of a drug-event association between angioedema and mifepristone. The (b) (6) reviewer recommends the inclusion of anaphylaxis and angioedema within the Mifeprex labeling, specifically to the Contraindications and Adverse Reactions Postmarketing Experience sections.

**Reviewer Comment:**

**There does appear to be an association with angioedema and mifepristone administration. The reviewers agree with inclusion of anaphylaxis and angioedema in the labeling for Mifeprex and with continued pharmacovigilance for anaphylaxis.**

## 9 Appendices

### 9.1 Literature Review/References

This NDA review obviously involved an extensive review of resources and the peer-reviewed medical literature that was pertinent to the requested changes of the Applicant. Such sources are noted throughout the review in footnotes. A detailed Reference List is found in Appendix 9.6.

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**9.2 Labeling Recommendations**

The package insert (PI) for this product was submitted in the Physician Labeling Rule (PLR) format. Although not required for this supplement, Section 8 was revised in accord with the Pregnancy and Lactation Labeling Rule (PLLR). Section 17 Patient Counseling Information was also revised to be compatible with the new dosing regimen and follow-up. Major changes were made that updated the labeling with new safety and efficacy information, especially in two areas:

- 1) 6.1 Clinical Trials Experience in the section 6 Adverse Reactions
- 2) 14 Clinical Studies

Changes were also made in the patient package insert (PPI) and Medication Guide for the product. These format and content updates marked a significant improvement in the label. Agreement on the Final Approved label was reached with the Applicant on March 29, 2016.

**Reviewer comment:**

**The new dosing regimen was based on the extensive number of articles submitted by the Applicant from the peer reviewed medical literature. The revised label used the new PLR format which is a complete change from the previous style. This meant that the newly approved label was extensively rewritten and much improved from the old format.**

**9.3 Advisory Committee Meeting**

An Advisory Committee met in 1996 to discuss the approval of mifepristone plus misoprostol for medical termination of early pregnancy. There has been extensive US (15+ years with over 2.5 million uses) and global use (27+ years) of mifepristone and misoprostol for the medical termination of early pregnancy. No special external consultations were requested by the review Divisions. The FDA determined that the efficacy supplement did not raise complex scientific or other issues that would warrant holding an advisory committee meeting before approval of the supplement.

**9.4 (b) (6) Meeting**

As noted in Product Regulatory Information, Mifeprex was originally approved under 21 CFR part 314, subpart H, "Accelerated Approval of New Drugs for Serious or Life-Threatening Illnesses" (subpart H). Specifically, in accordance with § 314.520 of subpart H, FDA restricted the distribution of Mifeprex and required that Mifeprex be provided by or under the supervision of a physician who met certain qualifications. Further, practitioners had to complete a Prescriber's Agreement, provide patients with a Medication Guide and have patients sign a Patient Agreement. Mifeprex was included on the list of products deemed to have in effect an approved REMS<sup>86</sup> under section

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86 Federal Register / Vol. 73, No. 60 | Issued: March 27, 2008

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505-1 of the Federal Food, Drug, and Cosmetic Act with the passage of FDA Amendments Act (FDAAA) of 2007. A formal REMS proposal was submitted by Danco and approved on June 8, 2011, with the essential elements unchanged. The REMS included:

- Medication Guide
- Elements to Assure Safe Use (ETASU):
  - Prescribed only by certified prescribers (ETASU A; includes a Prescriber's Agreement)
  - Dispensed only in certain healthcare settings (ETASU C)
  - Dispensed with documentation of safe use conditions (ETASU D; includes a Patient Agreement)
- Implementation System
  - Distributed only by certified distributors

Following this approval, two REMS assessment reports were completed. The Year 1 assessment was completed on June 1, 2012 and the Years 2-4 assessment was completed on June 2, 2015. Agency review of these reports determined that the REMS goals were being met and that no modifications were required to the REMS at that time.

On July 16, 2015, the Applicant submitted a revised REMS as part of the efficacy supplement. The proposed modifications included:

- Prescriber's Agreement Form
  - Remove "Under Federal law"
  - Replace "physician" with (b) (4)

The Agency determined that broader review of the REMS was warranted concurrently with the efficacy supplement because some proposed changes in labeling dovetail with proposed changes to the REMS, and the documents should remain consistent with each other. Further, extensive review of the postmarketing experience based on the literature submitted to support the efficacy supplement, and pharmacovigilance, suggested that certain components of the REMS may no longer be necessary to assure safe use of Mifepr.

In light of the efficacy review, upon assessment of the proposed modifications, (b) (6) concurs with (b) (6) recommendations that:

- Removal of "under Federal law" from the Prescribers' Agreement was acceptable (see discussion in Additional Submissions / Issues)
- The term "healthcare providers who prescribe" is preferable to (b) (4) (see discussion in Additional Submissions / Issues)

(b) (6) and (b) (6) also proposed the following modifications:

- Removal of the Medication Guide from the REMS (will remain a part of labeling and must be distributed by the prescriber as required under 21 CFR part 208)
- Removal of the Patient Agreement form - Documentation of Safe Use (ETASU D)

## Clinical Review

(b) (6) and (b) (6)  
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- Revision of the Prescriber's Agreement form
- Revision of the REMS goal to reflect above changes

FDA considered the need for the current adverse event reporting requirements under the REMS, which are currently outlined in the Prescriber's Agreement to include "hospitalization, transfusion or other serious event." FDA has received such reports for 15 years; the safety profile of Mifepr is well-characterized, no new safety concerns have arisen in recent years, and the known serious risks occur rarely. For this reason, the reviewers do not believe ongoing reporting of all of the specified adverse events is warranted. The Applicant will still be required by law, as is every NDA holder, to report serious, unexpected adverse events as 15-day safety reports, and to submit non-expedited individual case safety reports, and periodic adverse drug experience.

(b) (6) and (b) (6) met with the (b) (6) on January 15, 2015, to discuss the proposed modifications. The (b) (6) concurred with the removal of the term "under Federal law" and with use of the term "healthcare providers who prescribe." The (b) (6) also concurred with the removal of the Medication Guide (MG) from the REMS, though the document would remain a part of labeling. FDA has been maintaining MGs as labeling but removing them from REMS when, as here, inclusion in REMS is not necessary to ensure that the benefits of a drug outweigh the risks, such as when the MG is redundant and not providing additional use or information to the patient about the risk(s) the REMS is intended to mitigate. This is consistent with ongoing efforts to streamline REMS by allowing for updates to the MG without need for a REMS modification. (b) (6) and the (b) (6) had subsequent interactions and on February 23, 2016, the (b) (6) concurred with the decision to remove the Patient Agreement (ETASU D) from the REMS. This decision was based on the following rationale:

- The safety profile of Mifepr is well-characterized over 15 years of experience, with known risks occurring rarely; the safety profile has not changed over the period of surveillance
- Established clinical practice includes patient counseling and documentation of Informed Consent, and, more specifically with Mifepr, includes counseling an all options for termination of pregnancy, access to pain management and emergency services if needed. The National Abortion Federation (NAF) provides clinical practice guidelines<sup>Error! Bookmark not defined.</sup> and evidence shows that practitioners are providing appropriate patient counseling and education; a survey published in 2009 demonstrated that 99% of facilities surveyed provided pre-abortion counseling with patient education.<sup>87</sup> This indicates that the Patient Agreement form is duplicative and no longer necessary to ensure that the benefits of the drug outweigh the risks.

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<sup>87</sup> O'Connell K, Jones HE, Simon M, Saporta V, Paul M, Lichtenberg ES. First-trimester surgical abortion practices: a survey of National Abortion Federation members. Contraception 2009; 79: 385–392.

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- Medical abortion with Mifepr is provided by a small group of organizations and their associated providers. Their documents and guidelines cover the safety information that is duplicated in the Patient Agreement.
- ETASUs A and C remain in place: The Prescriber's Agreement under ETASU A requires that providers "explain the procedure, follow-up, and risks to each patient and give her an opportunity to discuss them." The REMS will continue to require that Mifepr be dispensed to patients only in certain healthcare settings, specifically, clinics, medical offices, and hospitals. This ensures that Mifepr can only be dispensed under the supervision of a certified prescriber at the time the patient receives treatment with Mifepr.
- Labeling mitigates risk: The Medication Guide, which will remain a part of labeling, contains the same risk information covered under the Patient Agreement.

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## Clinical Review

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 NDA 020687/S-020- Mifeprex

## 9.4 Abbreviations

### List of Abbreviations

Abbreviation	Term
ACOG	American College of Obstetrics and Gynecology
APHA	American Public Health Association
CDER	Center for Drug Evaluation and Research
CDRH	Center for Devices and Radiological Health
(b) (6)	(b) (6)
<b>FU</b>	follow up
<b>GA</b>	gestational age
<b>IRB</b>	Institutional Review Board
<b>LFU</b>	lost to follow up
<b>LMP</b>	last menstrual period
<b>MAB</b>	medical abortion
<b>MG</b>	Medication Guide
<b>Miso</b>	misoprostol
<b>NA</b>	not applicable
<b>NAF</b>	National Abortion Federation
<b>NDA</b>	New drug application
<b>NR</b>	not reported
<b>NSAID</b>	non-steroidal anti-inflammatory drug
<b>PPFA</b>	Planned Parenthood Federation of America
<b>PREA</b>	Pediatric Research Equity Act
<b>REMS</b>	Risk Evaluation and Mitigation Strategies
<b>ROA</b>	route of administration
(b) (6)	(b) (6)
<b>SAB</b>	surgical abortion
<b>WHO</b>	World Health Organization

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FDA Label for Korlym:

[http://www.accessdata.fda.gov/drugsatfda\\_docs/label/2012/202107s000lbl.pdf](http://www.accessdata.fda.gov/drugsatfda_docs/label/2012/202107s000lbl.pdf)

FDA label for Mifepristone:

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**9.6 Mifepristone Approvals Globally**

**1988**

- China
- France

**1991-**

- UK

**1992**

- Sweden

**1999**

- Austria
- Belgium
- Denmark
- Finland
- Germany
- Greece
- Iceland
- Israel
- Luxembourg
- Netherlands
- Russia
- Spain
- Switzerland

**2000**

- Norway
- Taiwan
- Tunisia
- US

**2001**

- New Zealand
- South Africa
- Ukraine

**2002**

- Belarus
- Georgia
- India
- Latvia
- Serbia
- Vietnam

**2003**

- Estonia

**2004**

- Guyana
- Moldova

**2005**

- Albania
- Hungary
- Mongolia
- Uzbekistan

**2006**

- Kazakhstan

**2007**

- Armenia
- Kyrgyzstan
- Portugal
- Tajikistan

**2008**

- Nepal
- Romania

**2009**

- Cambodia
- Italy

**2010**

- Zambia

**2011**

- Ghana
- Mexico
- Mozambique

**2012**

- Australia
- Bangladesh
- Ethiopia
- Kenya

**2013**

- Azerbaijan
- Bulgaria
- Czech Republic
- Slovenia
- Uganda
- Uruguay

**2014**

- Thailand

**2015**

- Canada

Clinical Review

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NDA 020687/S-020- Mifepr

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**This is a representation of an electronic record that was signed electronically and this page is the manifestation of the electronic signature.**

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/s/

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(b) (6)

03/29/2016

(b) (6)

03/29/2016

(b) (6)

03/29/2016

I concur with (b) (6) conclusions and recommendations for approval of this efficacy supplement.

## CLINICAL FILING CHECKLIST FOR NDA/BLA or Supplement

NDA/BLA Number: 020687

Applicant: Danco Labs

Stamp Date: May 29, 2015

Drug Name: Mifeprex  
(Mifepristone)NDA/BLA Type: supplement  
#020

On initial overview of the NDA/BLA application for filing:

	Content Parameter	Yes	No	NA	Comment
<b>FORMAT/ORGANIZATION/LEGIBILITY</b>					
1.	Identify the general format that has been used for this application, e.g. electronic CTD.	x			Paper submission.
2.	On its face, is the clinical section organized in a manner to allow substantive review to begin?	x			
3.	Is the clinical section indexed (using a table of contents) and paginated in a manner to allow substantive review to begin?	x			
4.	For an electronic submission, is it possible to navigate the application in order to allow a substantive review to begin (e.g., are the bookmarks adequate)?			x	
5.	Are all documents submitted in English or are English translations provided when necessary?	x			
6.	Is the clinical section legible so that substantive review can begin?	x			
<b>LABELING</b>					
7.	Has the applicant submitted the design of the development package and draft labeling in electronic format consistent with current regulation, divisional, and Center policies?	x			
<b>SUMMARIES</b>					
8.	Has the applicant submitted all the required discipline summaries (i.e., Module 2 summaries)?		x		The applicant has not provided module 2 summaries as this is an NDA based on published literature. The applicant has provided a justification summarizing the evidence of safety and efficacy for the proposed changes.
9.	Has the applicant submitted the integrated summary of safety (ISS)?		x		See comment for 8.
10.	Has the applicant submitted the integrated summary of efficacy (ISE)?		x		See comment for 8.
11.	Has the applicant submitted a benefit-risk analysis for the product?	x			Scientific justification-30 pg document
12.	Indicate if the Application is a 505(b)(1) or a 505(b)(2).	x			(b) (2)
<b>505(b)(2) Applications</b>					
13.	If appropriate, what is the reference drug?			x	
14.	Did the applicant provide a scientific bridge demonstrating the relationship between the proposed product and the referenced product(s)/published literature?	x			The sponsor provides a bridge from the approved product to the proposed changes, with literature based

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## CLINICAL FILING CHECKLIST FOR NDA/BLA or Supplement

	Content Parameter	Yes	No	NA	Comment
					on both the approved product and the proposed regimen.
15.	Describe the scientific bridge (e.g., BA/BE studies)	x			See #14.
<b>DOSE</b>					
16.	If needed, has the applicant made an appropriate attempt to determine the correct dosage and schedule for this product ( <i>i.e.</i> , appropriately designed dose-ranging studies)?  Study Number: Many articles from the published medical literature.  Study Title: Sample Size: Arms: Location in submission:	x			
<b>EFFICACY</b>					
17.	Do there appear to be the requisite number of adequate and well-controlled studies in the application?  Pivotal Study #1 Indication:  Pivotal Study #2 Indication:	x			The applicant provides 54 articles total, with 32 specifically on efficacy of the proposed regimen. These include controlled trials, meta-analyses, observational and retrospective studies.
18.	Do all pivotal efficacy studies appear to be adequate and well-controlled within current divisional policies (or to the extent agreed to previously with the applicant by the Division) for approvability of this product based on proposed draft labeling?	x			
19.	Do the endpoints in the pivotal studies conform to previous Agency commitments/agreements? Indicate if there were not previous Agency agreements regarding primary/secondary endpoints.	x			
20.	Has the application submitted a rationale for assuming the applicability of foreign data to U.S. population/practice of medicine in the submission?		x		The applicant provides 54 articles total. 46 are studies (trials, retrospective, observational studies) and of these 17 are foreign. There are also 3 metanalyses which include foreign studies.
<b>SAFETY</b>					
21.	Has the applicant presented the safety data in a manner consistent with Center guidelines and/or in a manner previously requested by the Division?	x			The applicant provides 21 articles with information on safety, specifically on the serious adverse events of interest (hospitalization,

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## CLINICAL FILING CHECKLIST FOR NDA/BLA or Supplement

	Content Parameter	Yes	No	NA	Comment
					transfusion, infection requiring IV antibiotics, death). There are another 5 articles with limited safety information and 6 articles with safety information, but using different dosing regimens (e.g. not the approved or proposed new regimen).
22.	Has the applicant submitted adequate information to assess the arythmogenic potential of the product (e.g., QT interval studies, if needed)?			x	
23.	Has the applicant presented a safety assessment based on all current worldwide knowledge regarding this product?	x			
24.	For chronically administered drugs, have an adequate number of patients (based on ICH guidelines for exposure <sup>1</sup> ) been exposed at the dose (or dose range) believed to be efficacious?			x	
25.	For drugs not chronically administered (intermittent or short course), have the requisite number of patients been exposed as requested by the Division?	x			
26.	Has the applicant submitted the coding dictionary <sup>2</sup> used for mapping investigator verbatim terms to preferred terms?			x	There is no mapping of investigator terms to preferred terms. AE's were variably ascertained; 21 studies include data on SAE's of interest, 7 have limited safety information, 6 have safety information on the approved dosing regimen. Some 7 studies report no safety information.
27.	Has the applicant adequately evaluated the safety issues that are known to occur with the drugs in the class to which the new drug belongs?	x			
28.	Have narrative summaries been submitted for all deaths and adverse dropouts (and serious adverse events if requested by the Division)?			x	As of 7/16/15, there is one reported death; a complete report will be forthcoming. This

<sup>1</sup> For chronically administered drugs, the ICH guidelines recommend 1500 patients overall, 300-600 patients for six months, and 100 patients for one year. These exposures MUST occur at the dose or dose range believed to be efficacious.

<sup>2</sup> The “coding dictionary” consists of a list of all investigator verbatim terms and the preferred terms to which they were mapped. It is most helpful if this comes in as a SAS transport file so that it can be sorted as needed; however, if it is submitted as a PDF document, it should be submitted in both directions (verbatim -> preferred and preferred -> verbatim).

**CLINICAL FILING CHECKLIST FOR NDA/BLA or Supplement**

	<b>Content Parameter</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>	<b>Comment</b>
					is not part of the presently submitted application.
<b>OTHER STUDIES</b>					
29.	Has the applicant submitted all special studies/data requested by the Division during pre-submission discussions?			x	
30.	For Rx-to-OTC switch and direct-to-OTC applications, are the necessary consumer behavioral studies included (e.g., label comprehension, self selection and/or actual use)?			x	
<b>PEDIATRIC USE</b>					
31.	Has the applicant submitted the pediatric assessment, or provided documentation for a waiver and/or deferral?	x			The applicant requested a partial waiver for patients <12 and a waiver for patients 12-17, based on data from one study which included 322 subjects <17 years old.
<b>ABUSE LIABILITY</b>					
32.	If relevant, has the applicant submitted information to assess the abuse liability of the product?			x	
<b>FOREIGN STUDIES</b>					
33.	Has the applicant submitted a rationale for assuming the applicability of foreign data in the submission to the U.S. population?			x	29/46 studies are US data, 17 are based on foreign data.
<b>DATASETS</b>					
34.	Has the applicant submitted datasets in a format to allow reasonable review of the patient data?			x	NDA relies upon published studies; datasets were not provided.
35.	Has the applicant submitted datasets in the format agreed to previously by the Division?			x	
36.	Are all datasets for pivotal efficacy studies available and complete for all indications requested?			x	
37.	Are all datasets to support the critical safety analyses available and complete?			x	
38.	For the major derived or composite endpoints, are all of the raw data needed to derive these endpoints included?			x	
<b>CASE REPORT FORMS</b>					
39.	Has the applicant submitted all required Case Report Forms in a legible format (deaths, serious adverse events, and adverse dropouts)?			x	NDA relies upon published studies; CRFs were not provided.
40.	Has the applicant submitted all additional Case Report Forms (beyond deaths, serious adverse events, and adverse drop-outs) as previously requested by the Division?			x	
<b>FINANCIAL DISCLOSURE</b>					
41.	Has the applicant submitted the required Financial Disclosure information?			x	
<b>GOOD CLINICAL PRACTICE</b>					
42.	Is there a statement of Good Clinical Practice; that all clinical studies were conducted under the supervision of an			x	

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**CLINICAL FILING CHECKLIST FOR NDA/BLA or Supplement**

	<b>Content Parameter</b>	<b>Yes</b>	<b>No</b>	<b>NA</b>	<b>Comment</b>
	IRB and with adequate informed consent procedures?				

**IS THE CLINICAL SECTION OF THE APPLICATION FILEABLE? yes**

If the Application is not fileable from the clinical perspective, state the reasons and provide comments to be sent to the Applicant.

Please identify and list any potential review issues to be forwarded to the Applicant for the 74-day letter.

There is one review issue which will need to be addressed.

The proposed label contains information from the original studies and not from the studies supporting the new dosing regimen and the other proposed changes (e.g., including healthcare providers prescribing Mifepristone and home use of misoprostol). The Sponsor will need to update the proposed label.

	(b) (6)	7/16/15
Reviewing Medical Officers	Date	
	(b) (6)	7/16/15
	Date	

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**This is a representation of an electronic record that was signed electronically and this page is the manifestation of the electronic signature.**

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/s/

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